WAIVER OF PAYMENT

Patient Name: _____

Address: _____

From this date _____ forward to _____ I am excused from paying my:

❑ Deductible, or ❑ Co-payment, or ❑ Co-insurance; beyond:

$ _____

Due to economic hardship:
❑ Unemployed ❑ No insurance ❑ Bankrupt ❑ Dependent on Family for support
❑ Low or fixed income ❑ Student ❑ High medical expenses
❑ Not covered by State or local welfare programs
❑ Other: _____

Due to clinic policy:
❑ The medical clinic agrees to match your out-of-pocket expenses (as estimated) to that which you would normally have to pay to a preferred provider member of your insurance company.

_____

Due to high deductible:
❑ I have a substantially high insurance deductable that I cannot afford to pay. I ask that only some medical services (e.g., office visits) be billed to my insurance company. I agree to pay cash for other medical services (e.g., surgery) at a substantially reduced rate of:

$ _____
I agree not to bill any Insurance Company or ask the physician to bill any Insurance Company for these services. In the event of catastrophic illness or other reason, I do decide to submit these bills to my insurance company; I agree to be liable for all retail charges by said physician, without any limits that would otherwise be imposed by the discounted fee offered herein.

DATE: _____

PATIENT SIGNATURE * _____
*Note: This waiver is good for this physician provider only. We are not responsible for other health care providers or facilities that may participate in your care.

I waive the collection of the abovementioned unreimbursed medical charges.

STAFF SIGNATURE _____