

WAIVER OF PAYMENT

Patient Name: _____

Address: _____

From this date _____ forward/to _____ I am unable to pay the

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: _____

The reason is the medical clinic's policy 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.

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 _____