This Self-Pay Financial Agreement Waiver (“Agreement”) is intended to provide self-pay patients with an understanding of the financial aspects of healthcare services provided by Modern Orthopedics. Self-Pay patients should read this agreement carefully before making a decision and proceeding with treatment.

As a patient, who is covered by a medical or behavioral health care insurance plan you have the right to determine the best course of treatment. You understand that by signing this self-pay agreement that you have been informed that even if you are covered by an insurance plan, Modern Orthopedics will not be submitting any claims to the insurance plan on your behalf and you agree to not file a claim with your insurance plan.

Please read and acknowledge the following:

- ☐ I understand that Modern Orthopedics is not contracted with my insurance plan and will not be billing my insurance plan for any services provided by Modern Orthopedics.
- ☐ I understand that payment for the services I receive is due at the time of service, unless alternative arrangements have been approved in writing by Modern Orthopedics.
- ☐ I understand that Modern Orthopedics will not retroactively bill my insurance plan for any services provided while I am registered as a self-pay patient.
- ☐ I understand that I am voluntarily waving my right to directly submit my own claim for reimbursement to my insurance plan, and that I will be personally and fully financially responsible for all charges associated with services received from Modern Orthopedics.
- ☐ I acknowledge that this agreement does not prevent insurance billing by any hospital, anesthesiologist, physical therapist, imaging facility, or any other entity providing services during this episode, and the fee agreed upon specifically and exclusively applies to the fee due to Modern Orthopedics.
- ☐ I acknowledge that my payment for services provided by Modern Orthopedics will not apply to my deductible or maximum out-of-pocket cost as dictated by my insurance plan.
- ☐ I acknowledge that I have had the opportunity to ask questions regarding this waiver and my financial responsibility.

By signing, I acknowledge that I have read and understand this consent and agree to its terms

Patient Name: ______________________________ **DOB** ____________

Patient / Legal Guardian Signature: ______________________ **Date:** ____________

Witness (if required): ___________________________ **Date:** ____________