Austin Orthopedics and Sports Medicine

Insurance Coverage Waiver

PATIENTS WITH HEALTH INSURANCE

- ■ I do wish to receive medical service(s) from Dr. Kelso. I understand that in the event my health insurance company denies services rendered, ***I will be responsible for payment*** of all services provided.

PATIENTS WITHOUT HEALTH INSURANCE

- ■ I understand that I **do not** have any active health insurance at this time. I also understand that ***I will be responsible for payment*** of all services provided.

_____

Signature of Patient/Legal Guardian Date