

Waiver of Financial Screening

I do not wish to disclose my financial information for the consideration of free care services. I understand that by not disclosing this information, I will be determined ineligible for treatment on a free care basis. I understand that if Third Party Payer coverage applies, I will be responsible for any deductibles, co-payments, and/or non-covered charges and services. I understand that I do have the right to request a new screening at any time. If I wish to disclose financial information at that time, I may be considered for free care services.

Patient Signature