



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