HMO INSURANCE WAIVER FORM

I, _____ understand that I must have a referral prior to service at this office. If I do not obtain one beforehand, I understand that I am responsible for any and all costs accrued for my services. If the account becomes delinquent and is forwarded to a collections agency or an attorney, I understand that I am responsible for any and all additional fees incurred.

This agreement is effective _____ (Today's Date) between myself and The Foot Center, Inc.

Patient Signature: _____

Witnessed: _____