HEALTH INSURANCE RELINQUISHMENT FORM

Name of Patient: ____

Date of Procedure: ____

THIS IS A LEGAL DOCUMENT. READ IT CAREFULLY BEFORE SIGNING AND MAKE SURE ALL THE BLANKS ARE COMPLETED. YOU WILL BE LEGALLY BOUND BY THIS DOCUMENT.

The above referenced patient is scheduled for (procedure) ______________________________________ at INTEGRIS ___________________________________ (the "Hospital") on or about the date referenced above. I, ___________________________________, the patient, voluntarily wish to relinquish my right to file this claim to my health insurance company. I choose to be a private pay patient and acknowledge and understand that I am fully responsible for all charges associated with this Hospital procedure. I acknowledge and understand that this represents the Hospital charges only and does not include any physician or other professional charges, including, but not limited to radiologists, anesthesiologists, pathologists, etc., for which I will be separately billed.

I, the patient, agree to not file a claim to my health insurance company at a later date. If, for some reason, I do file a claim with my health insurance company and, regardless of their payment amount, I acknowledge and understand that I will not receive any type of refund from the Hospital for this particular Hospital procedure.

Patient acknowledges that Patient's Physician is required by law to obtain patient's consent to perform the procedure listed above and to inform patient of the risks, benefits and alternatives to the procedure. Patient is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantees or warranties have been made concerning the results of this admission or any procedures performed by Patient's Physician. Patient understands that Patient's Physician, his/her associates or assistants, shall be responsible for the performance of his/her own acts related to this admission and any procedures they perform. Hospital is not liable for the acts or omissions of Patient's Physician, his/her associates or assistants.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT, OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAS READ THE ABOVE, UNDERSTANDS ITS CONTENTS, ACCEPTS ITS TERMS, AND HAS RECEIVED A COPY.

__________________________________ Date: ___________________ Time: _____________
Signature

____
Signature of Guarantor (if applicable) Witness to Signature

IF PATIENT IS UNABLE TO SIGN:

____________________________________Date: ___________________ Time: _____________
Signature of Person Legally Authorized to Act for Patient