Patient Name: _____

MRN: _____

Date of Service: _____

PATIENT WAIVER AND AGREEMENT FOR PAYMENT

You have chosen to self-pay for health care services provided by the Public Health Clinic at Boston Medical Center. You have decided to self-pay even though you may have health insurance that covers these services and waive your right to have a claim submitted to your insurance company on your behalf.

The cost to you for an office visit in the Public Health Clinic is $75.00. For self-pay patients, certain laboratory tests associated with the clinic visit (Gonorrhea, Chlamydia, Syphilis and HIV) are performed by the State Laboratory at no additional charge to the patient.

Your signature below indicates that you have received a copy of this document and are aware that you are waiving your right to have a claim submitted to your insurance company. Payment is due in full on the date you are seen in the clinic.

Signature: _____

Date: _____