WAIVER OF FINANCIAL RESPONSIBILITY

ADVANCED PELVIC SURGERY, LLC
R. GREGORY OWENS, M.D. F.A.C.O.G.

PATIENT NAME: _____

PHYSICIAN NAME: R. Gregory Owens, M.D.

DATE OF SERVICE: _____

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES IN THE EVENT THAT MY INSURER DOES NOT COVER EXPENSES. IF YOU HAVE A DEDUCTIBLE AND IT HAS NOT BEEN MET, PAYMENT FOR SURGERY OR PROCEDURES WILL HAVE TO BE PAID BEFORE SERVICES ARE RENDERED. AN INTEREST CHARGE OF 1 ½ % PER MONTH WILL BE ASSESSED FOR ANY OUTSTANDING PATIENT BALANCE AFTER THE FIRST STATEMENT IS SENT.

TO ASSIST YOU WITH YOUR MEDICAL CARE, WE PROVIDE THE FOLLOWING PAYMENT OPTIONS:

1. **CASH – INCLUDES PERSONAL CHECKS**
2. **VISA, MASTERCARD, DISCOVER, DINERS CLUB, JBC, AMEX**
3. **CareCredit – Patient payment plans that allow you to pay over time with convenient low minimum payments. With CareCredit, you enjoy these benefits:***
    - **Flexible Financing options**
    - **No annual fees or prepayment penalties**
    - **Quick and easy application**
    - **Receive a credit decision almost immediately**
    - **Start your recommended treatment immediately**

SIGNATURE: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____

DATE: _____