Patient Waiver/Consent and Agreement to Pay Form

I, _____understand that by signing this waiver, I am agreeing to pay for any non-covered services provided by Dr. Howard B. Cotler.

Every billing effort will be made to obtain reimbursement of the services provided from my insurance carrier. In the event of a denial of payment by the insurance carrier, I agree to be responsible for the allowed amount of the charges or a remaining balance after my insurance has paid in full.

I have read, understand and have a copy of the Waiver/Consent and Agreement to Pay Form and accept all terms listed above.

Patient's Signature:_____Date:_____

Parent or Legal Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____