Milford Regional Physician Group

The Benchmark for Quality Care

Uninsured Patient Waiver

Date:_____

Patient Name:_____

Date of Birth:_____

Provider:_____

(Patient Full Name)

I,_____, acknowledge I do not have health insurance at the time of service today. I have made a payment in the amount of $_____ towards today's service. I understand there may be additional charges associated with the care provided today. It is my understanding that I am financially responsible if there is a balance due.

I am aware that I am eligible to receive a 30% prompt pay discount if payment is received within 30 days of the statement date.

I will call 1-888-617-2643 with any questions.

_____

Patient Signature