

KNEE CENTER OF WESTERN NEW YORK

100 CORPORATE PARKWAY

SUITE 112

AMHERST, NY 14226

PATIENT WAIVER FORM

It has been explained to me that the Knee Center of WNY may not participate with my health insurance plan. I understand that it is my responsibility to verify with my health insurance whether or not the Knee Center of WNY is a participating provider. I hereby agree to pay the full amount of my office visit/surgery at the time of service if they are a non-participating provider. I understand that any balance that has not been satisfied at the time of service will be due immediately upon receipt of my first statement. If payment is not received or other arrangements made, further collection activity will commence.

Patient Signature _____