DR. JEFFREY D. GABER
& ASSOCIATES, PA

SELF-PAY WAIVER FOR PRIVATE PATIENTS

I, ___________________________________, understand and agree that I will be held responsible for any and all services that I receive by and through Dr. Jeffrey D. Gaber & Associates, P.A., that are not covered by my health maintenance/insurance plan.

I further understand that I will be held responsible for payment of these services in full, in the event that my health insurance does not cover these charges.

Agreed ____

Date ____

Witness ____