DR. JEFFREY D. GABER
& ASSOCIATES, PA

SELF-PAY WAIVER

I, _____ , fully understand and agree that I will be responsible for any and all services that I receive by and through Dr. Jeffrey D. Gaber & Associates, P.A., related to an accident or injury that I sustained on or about _____ . Dr. Jeffrey D. Gaber & Associates, P.A., will not bill, nor accept payment from my private health insurance.

I also agree that if my injury claim is denied or in the event that any liability insurance payment or settlement that I receive is not adequate to cover these charges, that I will be held responsible for payment of these services in full.

STATUTE OF LIMITATIONS WAIVER

I, _____ ,do hereby waive my right to the three-year statute of limitations for the collection of any medical services provided by Dr. Jeffrey D. Gaber & Associates. P.A.

Agreed Signature _____

Date _____

Witness _____