SELF-PAY OBLIGATION

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 insurance/maintenance plan. If I receive any direct payments from my insurance carrier or any other payer for the purposes of payment of my medical bills for treatment with Gaber & Associates, PA, I agree to forward those amounts to Gaber & Associates, PA.

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.

If the patient is a minor and under my care, I am signing as the responsible party for any uncovered expense.

If the patient is an adult for whom I am the guardian, or over whom I have a financial power of attorney. I will take the proper actions within my power to make payment from the patient's funds on his or her behalf.

The undersigned expressly agrees that if, upon default, this matter is referred for collection, he/she agrees to pay reasonable COLLECTION fees of thirty-five percent (35%) for attorneys' fees and related costs of collection of the outstanding balance at the time of referral, which percentage and the amount resulting there from are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees

BY SIGNING BELOW, I ACKNOWLEDGE RECEIVING DR. JEFFREY D. GABER & ASSOCIATES, PA'S "NOTICE OF PRIVACY PRACTICES"

Patient's Name: ____

Date of Birth: _________________________

Signature of Patient or Legal Guardian: ____

Date: ___________________________

Witness: ____