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, or those provided to any child for whom I am the guardian, 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 or 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 personally responsible for payment of these services in full.

STATUTE OF LIMITATIONS TOLLING AGREEMENT

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

Any applicable statutes of limitations, statutes of repose, or other defenses I may have relating from a delay of enforcement to any claim by Dr. Jeffrey D. Gaber & Associates, P.A. that is not otherwise barred as of the date of this waiver, shall be tolled for three years from the final date I have to enforce an injury claim, final settlement or the final, non-appealable award of damages related to the accident or injury I sustained, whichever is later.

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: _____