SELF PAY CONTRACT

PATIENT NAME: ______________ . . ________________DOB: ______________DATE:_2/18/2021___

I, ____, agree to be a "self pay" patient and understand that payment for each visit will be due prior to initiation of treatment each visit. I also understand that Southern Maryland will NOT submit claims and Southern Maryland will not provide you with any documentation other than dates and amounts of payments received from you. You will be unable to submit the claims to your insurance company yourself and, therefore, the payments made to Centers for Advanced Orthopaedics will not be able to be applied toward your deductible and/or out of pocket maximums for your health plan.

Cost For Initial Evaluation (1st visit) - $_______

Cost for Follow Up Visits - $_______

Patient Name (Print)____
Date__________________

Patient Signature____Date__________________

Patient Rep/Guardian Signature___________________________________Date__________________