MIDLAND ORTHOPEDIC ASSOCIATES

PATIENT CO-PAY

ACKNOWLEDGMENT FORM

By signing this form I acknowledge that I am aware any co-pay that my insurance requires me to pay Midland Orthopedics is due at the time of service at check in. I recognize that my failure to pay the required co-pay at the time of service may result in my appointment being rescheduled.

Print Name:

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Patient Signature:

______________________________ **Date**________________________