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Account # _____

Out-Of-Network Waiver

I acknowledge that I have been advised that SportsMed-Wheaton Orthopaedics, Ltd. and its professional staff are not participating providers in my primary and/or secondary health insurance plan. As a result, benefits for any services I may receive from SportsMed-Wheaton Orthopaedics, Ltd. will **not** be paid at in-network rates.

In signing this waiver, I acknowledge that I have chosen to receive services from SportsMed-Wheaton Orthopaedics as an out-of-network patient. I understand that I bear full responsibility for all charges related to my treatment, and that SportsMed-Wheaton Orthopaedics offers no discount on out-of-network accounts.

Signature of Patient or
Parent/Guardian if Patient is a Minor

Date

Witness