Medicaid Waiver for Medical Services

I,_____, understand that I am choosing to see Washington Orthopaedics and Sports Medicine, who does not participate with **Medicaid** medical assistance program. By doing so, I understand that I am fully responsible for all fees from services rendered on the dates below. The fees include, but are not limited to, office visits, medical equipment, and surgery.

_____ _____

Signature Date

_____

Witness Signature