ISLAND HEALTH & WELLNESS CENTER

I, ______________________________(name), attest that I will not file a claim or seek any reimbursement from Medicare or Medicaid for the services I receive at Island Health & Wellness Center. I agree to pay the charge put forth by Island Health & Wellness Center, therefore forfeiting any right to reimbursement for services I receive at Island Health & Wellness Center through Medicare/Medicaid.

______________________________ (Print Patient/Guardian Name)

______________________________ (Signature of Patient/Guardian)

______________________________ (Date)