ACKNOWLEDGEMENT OF PATIENT ELECTION TO SELF-PAY

I hereby acknowledge that I have elected to schedule and receive health care services without utilizing health insurance or any benefit plan that may be available to me. By electing to self-pay, I agree that I will bear full responsibility for covering the cost of these services out-of-pocket. Consequently, I understand that no insurance claims will be submitted on my behalf for these services, and that the payments I make will not count towards any applicable health insurance deductibles.

By my signature below, I accept responsibility for the payment of professional, facility, and technical fees associated with the health care services I will receive from The San Antonio Orthopaedic Group, LLP ("TSAOG"), including services provided by TSAOG's affiliated clinicians and facilities. I affirm that I have carefully reviewed this document, am fully aware of its content, and have been afforded the opportunity to ask questions about it. I certify that I am either the patient or the patient's duly authorized representative.

_____

Patient or Representative Signature

Date _____ Time_____ Patient ID_____

If signed by someone other than the patient, please specify relationship to the patient:

_____

Service: _____ Estimated Cost:_____