Bridger Psychiatric Services

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Kenneth C. Olson M.D., M.S.

MEDICAID COMPENSATION WAIVER STATEMENT

By signing this form you are indicating that you choose to personally pay for psychiatric services received from this clinic (BPS) and it's providers, and to not utilize your Medicaid benefits to pay for these services.

This is necessary because BPS does not currently participate as a Medicaid provider. In the meantime, if you choose to rescind this agreement while receiving care in this clinic, BPS will cooperate with transfer of your psychiatric care to a provider who does accept Medicaid.

I have read the statement above, my questions have been answered, and I agree to this arrangement.

_____ _____
(Provider's Signature) Date

_____ _____
(Patient's Signature) Date

_____ _____
(Patient's Legal Representative Signature if applicable) Date

_____ _____
(Witness) Date