John R. Budden, M.D. APMC
Orthopedic Surgery

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PATIENT INSURANCE ACKNOWLEDGEMENT FORM

DATE: _____

By signing this statement, I am acknowledging that I want Dr. John Budden's office to file my current injury/condition: _____, on my Personal Insurance: _____. I acknowledge that this is not due to any type of work-related injury/condition or liability.

I also understand that once I sign this statement, I agree that Dr. John Budden's office will not file any Workers Compensation Claim or Liability Claim should I decide that this injury/condition become work related or a liability at a later date.

Patient Name: (please print) _____

Patient's Signature: _____

Witness: _____