

PRIVATE PAY
AGREEMENT

I understand Dr. M. Mitchell Silver is accepting me as a private pay patient. These services may include but not limited to:

- *New Patient
- *Established Patient
- *Pregnancy
- *Annual
- *Illness
- *Surgery
- *Office Procedures (Ultrasound/Leep/Urodynamics/Colpo)
- *Other: _____

I acknowledge that I will be responsible for paying for any services I receive. Dr. M. Mitchell Silver will not file a claim to Medicaid for services provided to me.

Date: _____

Signature of Patient: _____

Printed Name: _____

Witness (Staff Member): _____

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