PATIENT BENEFIT
FOUNDATION

Waiver of Liability

Patient Benefit Foundation provides charitable financial assistance to eligible patients for approved surgical care. PBF does not provide medical treatment, practice medicine, or make medical decisions regarding a patient's diagnosis, procedure, treatment, or follow-up care.

I understand that my surgeon, hospital, surgical facility, anesthesiologist, and any other healthcare professionals involved in my care are responsible for the medical services they provide. PBF is not responsible for the medical judgment, acts, omissions, treatment decisions, or outcomes of independent healthcare providers.

I understand that all surgical procedures involve risks and possible complications. I am responsible for discussing the specific risks, benefits, alternatives, expected outcomes, and any questions or concerns regarding my procedure with my treating healthcare provider before surgery. My healthcare provider, not PBF, is responsible for obtaining my informed consent for the procedure.

I agree to provide complete and accurate medical information to my healthcare providers and to follow all pre-operative and post-operative instructions given to me. I will attend required follow-up appointments, ask for clarification when instructions are unclear, and promptly contact the appropriate healthcare provider if I experience concerning symptoms or complications.

I understand that PBF's financial assistance is limited to expenses specifically approved by PBF. Any approved assistance, including the surgical procedure, hospital or facility stay, and post-operative visits, will be subject to PBF's eligibility requirements, funding approval, program limitations, and the terms stated in my approval or award documentation. I understand that expenses not specifically approved by PBF are my responsibility unless otherwise agreed to in writing.

To the extent permitted by applicable law, I acknowledge that PBF is not responsible for complications, injuries, losses, damages, or other outcomes resulting from medical treatment or services provided by independent healthcare providers. Nothing in this agreement is intended to waive rights that cannot legally be waived.

By signing below, I acknowledge that I have read and understand this agreement, have had the opportunity to ask questions, and am signing it voluntarily. I understand the role and limitations of Patient Benefit Foundation and understand that questions regarding my medical care should be directed to my healthcare provider.

I, _____ fully understand and agree to the above terms.

_____ _____

Patient Signature: Date: