Insurance Agreement

Patient's Name________________________________Date____________________

I understand that my insurance or healthcare plan may not provide coverage for such items as deductibles, co-payments, non-covered health services, including supports and vitamins, and that I am responsible for all services received.

_______ I understand that I owe 100% of my bill and that I am responsible. I agree to pay balance in full.

_______ I have been advised that if my insurance coverage should terminate during my care, I will be financially responsible for services rendered to me after that date.

_______ I agree that I will bring in any payment received from the insurance company for services received at Saint Camillus Urgent Care.

Patient's Signature_________________________________ Date__________________