Billing Agreement and Handout Reception Confirmation

I understand and agree that I need to provide timely updates (within 30 days of any change) to my demographics, including but not limited to changes in, name, address, phone number, email address, insurance company and or member ID number, primary pharmacy, guarantor status, emergency contact, and any person(s) authorized access to my medical records.

I understand that my insurance company can reverse claim decisions up to seven years after the initial date of service, and I agree to keep Town Family Doctor, PLLC updated of my current address for that time period. I agree to cover any balance resulted from an overturning of a claim decision by my insurance company.

I understand that any procedure, lab, or service can be denied coverage by my insurance company, and that Town Family Doctor, PLLC cannot guarantee coverage on any services ordered and/or performed. I also understand that it is MY responsibility to check coverage with my insurance company for any services ordered by and/or performed at Town Family Doctor, PLLC, prior to their completion. By signing this agreement, I agree to be responsible for any balance resulting form services at Town Family Doctor, PLLC, resulted from a coverage denial by my insurance company, and will dissolve Town Family Doctor, PLLC from any responsibility for compensation as a result of such denial taking place.

By signing this agreement, I acknowledge that I have received, read, and understood the information being presented to me in this form and in the handout package form entitled Town Family Doctor Policies

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Patient Name (Please Print) Date

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Patient Signature