Financial Responsibility

I agree that I am financially responsible for all charges related to services provided by T-Force Health. If I have questions about my financial responsibility for T-Force Health's charges, or would like to see a copy of T-Force Health's collection policy; I may contact T-Force Health's Financial Services.

Further, if I am provided health care services by a health care provider other than T-Force Health, while a patient within a T-Force Health facility or entity, I am financially responsible for all charges related to services provided by those health care providers. T-Force Health's billing statements will not include charges by health care providers who are independent of T-Force Health.

Additionally, I agree T-Force Health, or its third-party vendor, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ASSIGNMENT OF PAYER BENEFITS

I agree T-Force Health and my attending health care provider will bill and provide necessary health information to any Payers.

"Payers" are my health care insurance, private or government health plan or insurance health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All payers may make payments directly to T-Force Health and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any payer to T-Force Health and my attending health care provider. I agree that unless T-Force Health or my attending health care provider have agreed with the payer to accept payment form the payer as full payment, I am responsible to pay any charges not pain by the pater. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNEMTN OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits by made on my behalf to T-Force Health and my attending health care provider for any services furnished. Me by T-Force Health and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

ACKNOWLDGEMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's

behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

Signature of Patient or Authorized Person: _____
Date: _____

Relationship to patient (if not patient signing): _____
Date: _____