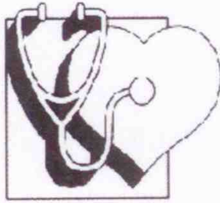

Letitia C. Thompson-Hargrave DO
513 East Stroop Road
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Toll Free: (877) 293-2157
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FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED.

Payment Policy: I understand that if this office may be a participating provider with my insurance, and if I am responsible for any deductible or copayment, I am required to pay it at the time the services is rendered. If this office is not a participating provider with my insurance, I understand that I am expected to pay my bill IN FULL at the time the service is rendered. If I am unable to do so, arrangements must be made in advance and with the provider's approval. Letitia C. Thompson-Hargrave, D.O., out of courtesy, will submit a claim to my insurance company on my behalf. I agree to assign and authorize payment made directly to Letitia C. Thompson-Hargrave, D.O. of all insurance benefits. I understand it is mandatory to notify my health care provider of any other party who may be responsible for paying for my treatment.

Release of Information: I hereby authorize this office to furnish information from my medical record to any health care provider who she deems necessary to provide continuity of my care. I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for any Medicare of other insurance claim. I permit a copy of this authorization to be used in place of the original and note that I may withdraw my authorization at any time via written notification to the parties involved.

I understand that I am financially responsible for any balance not covered or payable by my insurance plan.

SIGNATURE ________________________________ DATE ______________________