Patient Financial Responsibility, Notice of Policy and TCPA Consent to Call Agreement

Your signature below forms a binding agreement between **Dr. Jon's Urgent Care Center** (the provider of services) and the Patient who is receiving services, or the Responsible Party (when applicable). Responsible Party is the individual who is financially responsible for payment of bills.

It is the Patient or the Responsible Party responsibility to:

- Inform **Dr. Jon's Urgent Care** of the current address and phone number for the patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current.
- Pay any required copay or date of service.
- Pay any balance due in full within 30 days of receiving a statement from our office.

TCPA – CONSENT TO CALL:

By signing this agreement you authorize and give **Dr. Jon's Urgent Care Center** and its respective agents consent to contact you regarding any matter related to your office visit, balances due on accounts and in any attempt to collect a debt that you owe to **Dr. Jon's Urgent Care Center** for services rendered. By signing this agreement you give your consent to be contacted at the current number (s) provided to **Dr. Jon's Urgent Care Center** or it's respective agents or any future phone number (s) that you provide for your cellular phone or any landline phone that you may have.

COLLECTION FEES AND EXPENSES:

You understand and acknowledge that you are responsible for any fees or expenses, including reasonable attorney's fees and collection agency fees incurred **Dr. Jon's Urgent Care Center** in collecting any balances due under the terms of this Agreement. Fees will be in addition to the balance due.

By signing below, you understand agree to accept FULL FINANCIAL RESPONSIBILITY as a patient who is receiving services or as the parent/guardian for the patient. You authorize payment of benefits to **Dr. Jon's Urgent Care Center** .Your signature verifies that you have read the above, had the opportunity to ask and have answered any questions, understand your responsibilities, and agree to these terms.

____**Date** ____________________
Signature of patient: (Parent or Guardian if patient is a minor)

____**Date**:____________________
Witness