Patient Eligibility Form

I, the undersigned, do hereby agree to be financially responsible for all charges incurred by me for professional services rendered to me. In the event I am not eligible under my health insurance or other form of health care coverage, I state to be eligible for such coverage at this time whether verifiable or not and agree to assume all financial responsibility for any and all services provided to me by the doctor.

Signed:_____ Date:_____

Print Name:_____

Witness: (sign)_____ Date:_____

Print Name:_____