Duty of Payment

I, ______________________, have requested Ethos Clinics to bill my insurance on my behalf for payment of services. I clearly understand that it is my responsibility to be financially responsible for services rendered.

This is including but not limited to; insurance adjustments, denied claims, or services not covered by my plan. If there is a balance owed on my account, I agree to make arrangements for prompt payment.

I understand if my benefits or coverage should change while I am receiving treatment, I must notify Ethos Clinics immediately in order for proper insurance claims information to be submitted on my behalf.

Furthermore, if my insurance company does not pay the provider directly, I agree to relinquish payment to Ethos Clinics upon receipt of the check.

My signature indicates that I have read and understand the policy above.

Print Name of Patient:____________________ **Signature**:_____________________

Print Name of Policy Holder if Different from Patient:

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Signature of Policy Holder if Different from Patient:

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Witness:________________________________ **Date:**_____________________