GRACE MEDICAL OF TROY
DR. NANCY MANSOUR-HABIB
Beaumont® Staff

Financial Responsibility Form

I ___________________________________, am aware that if my insurance company does not cover my primary care physician's visit or any other procedure done in the physician's office, that I will be held responsible for all the charges due of the services rendered to me.

Patient Signature:____

Patient Date of Birth:____

Witness Signature:____

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