Public Health
Prevent. Promote. Protect.
Tuscarawas County
Health Department

Form: 2023-17

Physical Financial Agreement

Patient Name (Print) _____ Date of Birth: _____

PLEASE CHOOSE ONLY 1 OPTION

Check the box next to your choice

☐ I agree to pay out of pocket for today's visit for a physical and understand that I am paying $30.00 due at the time of the visit. I understand my insurance will not be billed for the physical portion of this visit. If I receive a vaccine(s), my insurance will be billed accordingly and there may be an additional fee and/or co-pay due at time of the visit.

☐ I am choosing to have my insurance billed for today's visit for a physical and understand that I may receive a bill from the Tuscarawas County Health Department if my insurance doesn't cover the cost of the visit. If I receive a vaccine(s), my insurance will be billed accordingly and there may be an additional fee and/or co-pay due at time of the visit.

_____ _____

Signature of Patient or Patient's Representative Date

3/1/22ak; 5/15/23 CRM

897 E. Iron Ave.
Dover, OH 44622

(330) 343-5555
(330) 343-1601

www.tchdnow.org
director@tchdnow.org

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