Tuscarawas County
Health Department

Form: 2023-17

Physical Financial Agreement

Name of Patient______________________

I understand I am paying $_____________________for today's visit for a physical

I understand my insurance will not be billed for the physical portion of this visit. If I receive a vaccine, my insurance will be billed accordingly and there may be an additional fee and/or co-pay due at time of the visit.

________________________________ ______________

Patient Date

OR

________________________________ ______________

Parent/Guardian Date

3/1/22ak

897 E. Iron Ave.
Dover, OH 44622

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

www.tchdnow.org
director@tchdnow.org