# THIBODAUX REGIONAL WOMEN'S CLINIC

## Agreement to Accept Responsibility

## (No Insurance Card)

**I have presented for services without a current insurance card. I understand that it is my responsibility to provide the full name, address, and phone number of the insurance company along with the insured's full name, date of birth, policy ID number, group number, relationship to insured and employer name and address. I will assume full responsibility for today's services if the information is not provided, provided incorrectly, or if a claim is denied to the information provided.**

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**Patient Signature** **Date**

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**Print Name**