TREASURE COAST Primary Care

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# SELF-PAY PATIENTS

AUTHORIZATION AND NOTICE

**Notice To ALL Self-Pay Patients:**

It has been explained to me by the staff that any extra testing or procedures will constitute additional charges for today's visit and are **NOT COVERED** under the initial office visit fee. I understand that payment in full is required at the time services are rendered.

_____

Patient Name (please print)

_____ _____

Patient Signature Date

_____

Witness – Authorized Staff Signature