

HEALTHCARE ON THE SQUARE

Boydton Community Health Facility, Inc.
380 Washington Street
Boydton, Virginia 23917

Annual Advance Notice of Responsibility

Patient's Name: _____ **Date of Birth:** _____

NOTICE: You need to make a choice about receiving health care items or services.

<input type="checkbox"/> YES, I want to receive services. I understand that it is my responsibility to know what services my insurance plan or Sliding Fee Program covers. I understand that if I receive services without a referral/authorization on file that I will be responsible for any balance. I understand that if my insurance or Sliding Fee has been terminated or I am not eligible on the date of service that I will be responsible for any balance. I understand that in the event that my insurance does not cover any of the treatment/services that are/will be rendered, I will be responsible for the outstanding charges. I agree to be personally and fully responsible for any balance.
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Provider rendering services:

Boydton Medical:
Dr. Crowder
Carolyn Leach, CWHNP
& Locum Tenen

Family Counseling:
Dr. Frank
Linda Montgomery, LPC

Halifax:
Dr. Ketchersid

Today's Date: _____

Patient: _____

Guarantor (if different from patient): _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

**This form covers all dates of service one year from date of signature.*