



Life Savers
EMERGENCY ROOM
Always Open . Always Ready

17685 TOMBALL PARKWAY
HOUSTON, TX 77064
PHN: 832-779-5433 FAX: 832-604-5433

3820 NORTH SHEPHERD DR. SUITE A.
HOUSTON, TX 77018
PHN: 281-766-8911 FAX: 832-742-9896

Patient Label

LIFE SAVERS ER PATIENT PAYMENT POLICY & AGREEMENT

In consideration of my particular Medical needs and Care expenses to be incurred solely based on such Medical needs, and my financial ability to pay for such recommended Medical services without or even with applicable Insurance Coverage, and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional actual total charges regardless of any applicable insurance coverage.

[] I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:

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[] I will pay Full or any charges for my medically necessary care expenses.

If the responsible party or the responsible party insurance does not cover some or all of the my medically necessary care expenses or if my claim is denied. I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs.

Patient Name: _____

Signature of Patient: _____

Date: _____

Staff Witness: : _____

Date: _____