ACKNOWLEDGEMENT OF BLOOD TESTING

I, ___________________________________ am aware that my insurance may not cover *all blood testing*, including STD testing. I ______________________________ will be fully responsible for any unpaid charges, for any blood work, that my insurance will not cover.

Any bill addressed from a laboratory will need to be handled with that laboratory

TOTAL FAMILY CARE IS NOT RESPONSIBLE FOR ANY TESTING THAT MY INSURANCE WILL NOT COVER.

____ ____________________

Patient Signature **Date**

____ ____________________

Parent/Guardian Signature **Date**

____ ____________________

Witness Date