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**Financial Liability Policy
(Print Clearly)**

I _____ (D.O.B.) _____, am eligible
with the following health insurance company _____
under the subscriber _____ with SS# _____
through his or her employer _____. I understand
that if the above is not true or if I am not eligible under the terms of my Medical
Subscriber Agreement, I (or responsible person) will be held liable for any and all
charges for services rendered on this day. Also, if the above is not true, I (or responsible
party) agree to pay in full for all services rendered within thirty days of receiving a bill
from Marathon Medical Group.

Signature _____
(RESPONSIBLE PARTY)

Responsible Party

Name: _____ Date: _____

Address: _____ Witness: _____

(Office use only)

City: _____ Zip: _____

Phone (____) _____ - _____