Statement of Financial Responsibility

I understand that I am responsible for any co-pays, coinsurances, deductibles, or non-covered services provided by SOS Health Care.

*(Please contact your insurance company for more specific information on your coverage)***.**

I agree to personally make any payments for ABA services provided for my child

by SOS Healthcare inc at the rate of $ 35 per hour in the event that ABA services

are not reimbursed my funding source and/or my private insurance.

Please be sure to let the billing staff know if your insurance changes in any way

i.e.: cancelation/ new insurance / change in insurance etc

I further understand that once I receive my invoice I have 30 days to pay the bill in full.

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Print Name

___________________________________ ________________
Signature Date