



**TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
AUTHORIZATION OF FULL FEE**

I, _____ acknowledge that the services provided by the
Patient Name

_____ County Health Department are not covered by my
TennCare/Medicare or other insurance coverage, because I have chosen not to be seen by my
Assigned/Network Provider. Since these services are covered only if my Assigned/Network Provider sees me,
I will be responsible for any and all charges that result from these services and my TennCare/Medicare or
other insurance will not be billed.

_____ Witness	_____ Patient/Guardian Signature	_____ Date
_____ Witness	_____ Patient/Guardian Signature	_____ Date