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Financially Responsible Adult and Insurance Company Information

IMPORTANT: We need parent's information in case we need to contact them for some reason.

Patient

Name_____DOB_____ SS# _____ ☐ Male ☐ Female

Address_____City/State_____Zip_____

Medicaid _____ CSHS_____ Lives With_____ Phone ( )_____

Father/Stepfather Financially Responsible for Patient: ☐ No Ins ☐ Primary Ins ☐ Secondary Ins

Name_____DOB_____SS#_____ ☐ Single ☐ Married

Address_____City/State_____Zip_____

Home Phone ( ) _____Wk Phone ( ) _____Cell Phone ( )_____

Employer_____Address_____Zip _____

Ins. Co._____City/State_____Phone( )_____

Group#_____Emp ID#_____Pt ID#_____

Mother/Stepmother Financially Responsible for Patient: ☐ No Ins ☐ Primary Ins ☐ Secondary Ins

Name_____DOB_____SS#_____ ☐ Single ☐ Married

Address_____City/State_____Zip_____

Home Phone ( ) _____Wk Phone ( ) _____Cell Phone ( )_____

Employer_____Address_____Zip _____

Ins. Co._____City/State_____Phone ( )_____

Group#_____Emp ID#_____Pt ID#_____

I have carefully read and inspected all of the above information and I attest that the information is true and accurate and that employment info and insurance coverage is current as of today's date. If my insurance does not pay as estimated, I agree to be responsible for the additional cost difference. Interest charges of 1.5% per month will be added to balances over 30 days past due. In the case of default of payment, I promise to pay for collection fees of 40%, attorney fees and court cost.

Name	Date	Relationship to patient