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ELIGIBILITY GUARANTEE/PATIENT FINANCIAL RESPONSIBILITY FORM

INSURANCE NAME: _____

INSURANCE ID: _____

GROUP NUMBER: _____ EFFECTIVE DATE:_____

SUBSCRIBER'S NAME: _____ D.O.B.: _____

NAME OF PERSON RESPONSIBLE FOR PATIENT (IF APPLICABLE):

PATIENT'S NAME: _____ D.O.B.: _____

ADDRESS: _____

TELEPHONE: _____

I, _____ HEREBY CERTIFY THAT I AM ELIGIBLE FOR

_____ INSURANCE.

IF POSITIVE VERIFICATION OF YOUR COVERAGE CAN NOT BE MADE AT THE TIME SERVICES ARE RENDERED, YOU WILL BE RESPONSIBLE FOR ALL SERVICES RENDERED TO YOU AT THE TIME OF THE VISIT.

I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED AND HERBY AFFIX MY SIGNATURE AS AN ACKNOWLEDGEMENT.

PATIENT'S SIGNATURE: _____ DATE: _____

GUARANTOR'S SIGNATURE: _____ DATE: _____