Rolling Oaks Pediatrics

Financial Responsibility

Patient Name(s): _____ _____

Patient Name(s): _____ _____

Father's Name: _____

Father's Address: _____

Father's Occupation: _____ Employer: _____

Contact Info: *Home*: _____ *Cell*: _____ *Email:* _____

Drivers License #: _____ Social Security #: _____

Marital Status: ☐ Married ☐ Divorced ☐ Remarried ☐ Single ☐ Widowed

Are you responsible financial responsible for this student's medical care? ☐ Yes ☐ No

If so, what percentage are you responsible for? ☐ 100% ☐ 50% ☐ Other _____

By signing below, I agree to financial responsibility towards these patient's medical expenses, including co-pays, deductibles and co-insurance. I also agree to provide up-date-insurance information.

_____

Signature *Date*

Mother's Name: _____

Mother's Address: _____

Mother's Occupation: _____ Employer: _____

Contact Info: *Home*: _____ *Cell:* _____ *Email*: _____

Drivers License #: _____ Social Security #: _____

Marital Status: ☐ Married ☐ Divorced ☐ Remarried ☐ Single ☐ Widowed

Are you responsible financial responsible for this student's medical care? ☐ Yes ☐ No

If so, what percentage are you responsible for? ☐ 100% ☐ 50% ☐ Other _____

By signing below, I agree to financial responsibility towards these patient's medical expenses, including co-pays, deductibles and co-insurance. I also agree to provide up-date-insurance information.

_____

Signature *Date*

NOTES: _____

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