## INSURANCE INFORMATION

INSURANCE COMPANY________________________________________________________

ADDRESS_____________________________________________________________________

CITY___________________________ STATE_______________ ZIP____________________

POLICY #___________________________ GROUP # ________________________________

## BILLING INFORMATION

PARTY RESPONSIBLE FOR BILL_________________________________________________

ADDRESS_____________________________________________________________________

CITY___________________________ STATE_______________ ZIP____________________

PHONE NUMBER_______________________________________________________________

SIGNATURE__________________________________________________________________

## PHARMACY INFORMATION

DRUG STORE NAME___________________________________________________________

PHONE NUMBER_______________________________________________________________

**PLEASE READ THE FOLLOWING STATEMENTS AND SIGN AND DATE BELOW:**

1) ALL COPAYS ARE DUE AT THE TIME OF SERVICE.
2) IT IS THE GUARANTOR'S RESPONSIBILITY TO INFORM THE FRONT OFFICE OF ANY INSURANCE CHANGES.
3) ANY VISIT UNPAID BY THE INSURANCE COMPANY OVER 90 DAYS WILL THEN BE THE GUARANTORS' RESPONSIBILITY.
4) PAYMENTS ON PAST DUE ACCOUNTS MUST BE MADE ON A MONTHLY BASIS IN ORDER TO BE CARRIED THROUGH THIS OFFICE.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR ACCOUNT, PLEASE CALL US AT (502) 339-0444.

I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY CHILD'S INSURANCE CARRIER. ANY DENIED CHARGES ARE PAYABLE WITHIN 30 DAYS IN FULL.
I HAVE READ THE ABOVE INFORMATION AND WAS PERMITTED TO ASK QUESTIONS, WHICH WERE ANSWERED TO MY SATISFACTION.

SIGNED_________________________________________________ DATE__________________

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