SPOUSE / OTHER RESPONSIBLE PARTY CERTIFICATIONS

Patient name: ____ Date: _________________

Responsible party name: ___________________________________ Relationship: ____________

Account #: _______________________________ Date of service: _______________________

____

Please place initials to the left of all applicable attestations.

____ I attest that I had **no income** for ______ months prior to the date of service.

____ I attest that I had **no assets** at the date of service or for ______ months prior.

____ I attest that I have **no medical insurance** through myself or any other party to cover the outstanding balance for services rendered to the patient on _________________ .

____ I attest that all information provided here is true and correct to the best of my knowledge.

____ I hereby refuse to provide any information.

Signature: ____ Date: ____________________

SPOUSE / OTHER RESPONSIBLE PARTY CERTIFICATIONS

Patient name: ____ Date: _________________

Responsible party name: ___________________________________ Relationship: ____________

Account #: _______________________________ Date of service: _______________________

____

Please place initials to the left of all applicable attestations.

____ I attest that I had **no income** for ______ months prior to the date of service.

____ I attest that I had **no assets** at the date of service or for ______ months prior.

____ I attest that I have **no medical insurance** through myself or any other party to cover the outstanding balance for services rendered to **the patient** on _________________ .

____ I attest that all information provided here is true and correct to the best of my knowledge.

____ I hereby refuse to provide any information.

Signature: ____ Date: ___________________