Kenwood
ALLERGY & ASTHMA CENTER, P.C.

Dr. Pamela A. Georgeson
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Minor Patient Financial Responsibility Acceptance

Patient Information:

Today's Date: _____ Date of Birth: _____

Name: _____

Address: _____

_____

Phone #: _____

Patient's Financial Responsible Party Information:

Date of Birth: _____

Name: _____ Relationship: _____

Address: _____

_____

Phone #: _____ Alternate Phone#: _____

Social Security Number: _____ Driver's License #: _____

I, _____, accept full financial responsibility for all balances that the above patient has at Kenwood Allergy and Asthma Center, P.C. I understand that any applicable insurance will be billed for the above patient's appointments and procedures and that I am responsible to pay any balance owed to Kenwood Allergy and Asthma Center carried by the patient.

Responsible Party Signature: _____

***This form must be accompanied by a copy of a valid photo i.d of the responsible party.**