

**HOSPITAL/CLINIC/DOCTOR
STUDENT/PATIENT INFORMATION**

Patient Name _____ Birth date _____ Age _____ Sex _____

Social Security Number _____

Allergies _____

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name _____ Relationship to Patient _____

Mailing Address _____ City _____ State _____ Zip _____

Social Security Number _____ Birth date _____ Phone _____

Occupation _____ Employer _____ Employer Phone _____

Employer's Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION:

Insurance Company _____ ID# _____

2nd Insurance Company _____ ID# _____

If the person responsible for this account is different than the person carrying the insurance on the patient we will need the following information for the person carrying the insurance on the patient.

Name _____ Relationship to Patient _____

Mailing Address _____ City _____ State _____ Zip _____

Social Security Number _____ Birth date _____ Phone _____

Occupation _____ Employer _____ Employer Phone _____

Employer's Address _____ City _____ State _____ Zip _____

NEAREST RELATIVE AND EMERGENCY CONTACT

Name _____ Phone _____ Relationship to Patient _____

Name _____ Phone _____ Relationship to Patient _____

By signing below I understand and agree that:

1. Professional Fees are due and payable at the time such services are rendered.
2. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned is entitled to hospital/clinic/doctor benefits for any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to patient, said benefits are hereby assigned and directed to the hospital/clinic/doctor.
3. **FINANCIAL AGREEMENT:** The undersigned agrees whether he signs as agent or as patient that in the consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital/clinic/doctor in full at discharge. Should account become delinquent and subject to collection action, the undersigned shall pay reasonable attorney's fees, court costs and collection expenses up to 50% of the principle owing. All accounts bear interest of 1.5% per month and 18% annually.
4. Medical information may be furnished to my insurance carrier at their request.

PRINTED NAME OF RESPONSIBLE PARTY _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

Kane County Hospital
Medical Expenses / Credit Card Authorization

This authorization is mandatory for all students who enter Abundant Life Academy. This Credit Card Authorization gives **Kane County Hospital** permission to use your credit card for the following expenses:

- ...Medication and Medication Co-pay - to include injections A.L.A. deems necessary
- ...Emergency Medical Treatment (if necessary)
- ...Medical Fees for Treating and Attending Physician - to include Co-Pay of Office Visit and any Lab orders the Physician deems necessary for treatment of your child.

Name

Students Name

Name on Credit Card (exactly as printed)

Billing address for Card

City, State & Zip

Type of Card (Visa, M.C., American Express, Discover)

Card Number

Expiration Date

Signature of Cardholder

Date