ALLIANCE CLINICAL
ASSOCIATES

7 Blanchard Circle – Suite 201 • Wheaton, IL 60189 • 630-653-2300

Financial Responsibility Form (Guarantor)

Patient Name: _____ **Age:** _____ **DOB:** _____

Guarantor for this account _____ **DOB:** _____

Relationship to patient _____

Street address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Guarantor employer _____

Business address _____

Occupation _____

Guarantor Social Security # _____ Driver's License # _____

I have received ACA's financial policy statement. As guarantor for this account, I acknowledge my responsibility for payment on this account until revoked by me in writing.

_____ Date _____
Guarantor's signature

Note: Alliance Clinical Associates will verify the patient's insurance benefits if we are billing insurance, but this verification is not a guarantee of payment. The guarantor (either the patient or person name) is responsible for payment of any and all balances on the account (copays, coinsurance amounts, visit charges not covered by insurance, phone consultation charges, and missed appointment charges.) If you have any questions regarding this patient's insurance coverage, please contact the insurance company for clarification. If you have any other questions regarding billing and insurance, please feel free to contact our office at (630) 653-2300, ext. 410.