PATRIOT
FAMILY
MEDICINE

Confirmation of Eligibility

Patient-_____-

Date of Birth-_____-

Social Security Number-_____-

I -_____-(patient) am eligible and have active Medical/Health coverage for services rendered with the following insurance company_____(name of the insurance company). My insurance is in good standing and active as of the following date _____(month) _____(day) _____(year). I have decided to have medical care and services provided by **Patriot Family Medicine** and understand if the information I have provided is not correct/true, I or the person responsible for all medical charges will be responsible for full payment within **21 days** of initially receiving notice or a bill from **Patriot Family Medicine.**

Signature Patient/Responsible Party-_____-

Date-_____-

***if patient is a minor, I authorize I am the parent/guardian ____(initial)**

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