

FOR OFFICE USE ONLY

Phone Y N Abby Y N

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No Info home Y N

**LAMPREY HEALTH CARE
TITLE X PROGRAM**

NASHUA TEEN CLINIC FINANCIAL ASSISTANCE APPLICATION

(Application must be completed with your information, signed and dated)

Last Name: _____ **First Name:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Legal Address (if different from mailing address): _____ **City:** _____ **State:** _____

Phone Number: _____

Family members Name:	Birth Date:	Sex:	Primary Language:	Country of Birth:	Interpreter Needed:
Self:					
Children:					

Income: _____ **None:** _____ **Insurance:** _____ **None:** _____

Primary Insurance: _____ **Subscriber name:** _____

Certificate# _____ **Group#** _____

Effective Date: _____

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the physician or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. At the end of sixty (60) days, billing is my responsibility. A copy of this signature is as valid as the original.

_____ Date _____
If you have insurance and you want us to submit a claim, sign here and below

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This is to certify that the above information is true, and I hereby authorize Lamprey Healthcare to verify and of the above data and release the above information to referring/mutual providers of care. I understand that I am financially responsible for all charges incurred. I understand that if I deliberately give false information related to my situation, now or in the future, I am liable for prosecution for fraud. I certify that the information provided is true and correct.

Signature Date