

**Alliance Clinical Associates, S.C.**  
**7 Blanchard Circle – Suite 201**  
**Wheaton, IL 60189**  
**630-653-2300**

**Responsibility Form for Legal Age Patient**

**Patient Name:** \_\_\_\_\_

Guarantor for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_

Guarantor employer \_\_\_\_\_

Business address \_\_\_\_\_

Occupation \_\_\_\_\_

Guarantor Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

**Check one**

- I understand that although my son\daughter is of legal age, I am taking responsibility for services rendered by the doctors and/or therapists at Alliance Clinical Associates during his/her office visits.
  
- My son\daughter is of legal age; therefore, I am not taking responsibility for services rendered by the doctors and/or therapists at Alliance Clinical Associates during her/her office visits.

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: ACA will be verifying the patient's insurance benefits if we are billing, but please keep in mind that this verification is not a guarantee of payment. The guarantor named will be ultimately responsible for payment of all and any balance 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, you need to contact your insurance company for clarification. If you have any other questions, please feel free to contact our office at (630) 653-2300, ext. 410.