The Steven A. Cohen Military Family Clinic at Easterseals

Financial Attestation

I,_____, declare that
(Client Name)

_____I understand my insurance will be billed. I will be responsible for my copay (if any is required) at the time of service from The Steven A. Cohen Military Family Clinic at Easterseals.

_____I am not covered by any insurance policy, through myself or any source at this time of treatment. Should any insurance become effective during my treatment I will notify the Clinic. I am requesting financial assistance from the Cohen Financial Assistance Fund to cover my treatment.

Whether or not I have insurance, I understand that payment will not be a barrier to receiving care at the Clinic and that financial assistance is available from the Cohen Financial Assistance Fund, if necessary. I further understand that funding from the Cohen Financial Assistance Fund is excess to all other insurance available.

_____ _____
(Client or Parent/Guardian signature if insured is a minor) **(Date)**

_____ _____
(Clinic Staff Witness) **(Date)**

FRAUD WARNING:
ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.