



Simon's Agency, Inc.

FILE PLACEMENT FORM

Please provide as much information as possible. Leave blank if unknown. We do not need copies of the statements or records, although we may ask for a copy at a later date.

FROM

YOUR ACCOUNT #	MOST RECENT DATE OF SVC	TOTAL OWED
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RESPONSIBLE PARTY

PATIENT

SSN	DOB
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SSN	DOB
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LAST KNOWN ADDRESS

LAST KNOWN ADDRESS

HOME PHONE

HOME PHONE

CELL OR OTHER PHONE

CELL OR OTHER PHONE

WORK PHONE

WORK PHONE

LAST KNOWN EMPLOYER

LAST KNOWN EMPLOYER

HAS INSURANCE BEEN APPLIED TO ACCOUNT?

YES NO

HAS MEDICAID/MEDICARE BEEN APPLIED TO ACCOUNT?

YES NO

COMMENTS / NOTES