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 PATIENT #	MOST RECENT DATE OF SVC	TOTAL OWED

RESPONSIBLE PARTY		**PATIENT**	
SSN	DOB	SSN	DOB

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?		*HAS MEDICAID/MEDICARE BEEN APPLIED TO ACCOUNT?*	
YES	NO	*YES*	*NO*
PRIMARY	SECONDARY		

COMMENTS / NOTES

4963 Wintersweet Drive
Liverpool, New York 13088

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Fax: 315-454-8885