PATIENT ATTESTATION FOR NO INSURANCE

PATIENT ATTESTATION FOR NO IDENTIFICATION

CARES Act COVID-19

Please print all information clearly

□ NO INSURANCE

I, _____, attest that I am uninsured effective as of

_____/_____/_____.

□ NO IDENTIFICATION

I, _____, attest that I am unable to provide identification

because _____.

Date of Birth (mm/dd/yyyy): _____/_____/_____

Social Security #: _____

Home Address: _____

Apt. _____

City, State _____

Zip Code _____

Home Number: _____

Cell Number: _____

I affirm that all information given on this attestation is true, complete, and accurate to the best of my knowledge.

Note: Patients will be billed if determined NOT a COVID-19 related illness.

Signed (patient): _____ Date: _____/_____/_____

Witnessed: _____ Date: _____/_____/_____