



Guarantor Designation & Financial Responsibility Form

Patient Information

Name: _____

Date of Birth: _____

Address: _____

Guarantor Information (Person Financially Responsible)

Name: _____

Relationship to Patient: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Email Address: _____

Please return completed form to:

US Acute Care Solutions
ATTN: Patient Services

4535 Dressler Rd. NW
Canton Ohio, 44718

ps@usacs.com

Fax: 330-492-8489

Insurance Information (if applicable)

Insured Name (if not patient): _____

Insurance Company: _____

Member ID: _____

Guarantor Acknowledgment & Financial Responsibility

I acknowledge that I am the designated guarantor, and I accept financial responsibility for all healthcare services provided to the above-named patient, including any amounts not paid by insurance.

I understand that providing the insurance information in this form does not guarantee payment and that I am responsible for any remaining balance, including copayments, coinsurance, and deductibles, in accordance with my insurance policy.

I further understand if the financially responsible party differs from the individual signing the consent at the time of service, it is my responsibility to ensure that the guarantor information is updated at the location where services are provided.

I certify that the information provided is accurate and complete to the best of my knowledge and agree to promptly notify the provider of any changes.

Guarantor Signature: _____ **Date:** _____



State of Ohio
County of _____

The foregoing Guarantor Designation & Financial Responsibility Form was acknowledged before me this _____ day of _____, 20__, by _____ (name of guarantor), who acknowledged executing the foregoing instrument for the purposes stated herein.

Notary Public, State of Ohio

Printed Name

My Commission Expires: