NORTHWEST HILLS
LONG TERM CARE

Patient Information

M _____
First Name Middle Last Spouse's Name

Address_____

City_____ **State**_____ **Zip**_____ **Phone**_____

Your SS# _____–_____–_____ **Tx. D.L.#** _____

Responsible Party _____ **Phone#**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Method of Payment (Please check one) **Credit Card** ☐ **Debit Card** ☐

Card#_____ **Expiration Date**_____

Billing Zip Code_____ **Authorization Signature**_____

I understand that as of January 1, 2006, there will be a charge for Medicaid prescriptions, and that I am responsible for this co-pay. If credit is extended pursuant to this application, I/We agree to pay all amounts due on this account in full within 10 days from the billing date on the statement. Liability on this account is joint and several on each of the undersigned. All past due accounts shall bear interest at 18% per annum from the date due until paid. This account is due and payable at the Company's office in Austin, Travis County, Texas. Under no circumstance does anything herein authorize the Company to charge, collect or receive usurious interest, and any amount which would otherwise be usurious shall be credited to principal or refunded to the undersigned or forgiven, as the case may be. You are authorized to contact all references above for information or credit verification.

_____ Signature

_____ Signature

Please Print

Date of Birth _____ Sex: Male / Female

Drug Allergies _____

Generic Substitution OK?_____

Insurance_____

PLEASE PHOTOCOPY INSURANCE CARD

NORTHWEST HILLS AT DAVENPORT - LONG TERM CARE
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