ACCOUNT CHANGE REQUEST

Date of Request: _______________

*Account cannot be separated if:
The patient is under 21
The patient is listed as a dependent on your insurance
The patient is not responsible for payment of his/her own account

*Account cannot be separated until:
All current insurance claims are paid by your insurance
You have a zero family balance

Reason for the account change request:

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Name and birthday of patient requested to be on a different account:

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If you are requesting to be added to an existing account, please list the name of the existing account:

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Name of responsible person for payment on the newly created account:

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Name of responsible person requesting the change in this account:

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Signature of responsible person authorizing the change in this account:

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