Statement of Financial Responsibility
Third Party Payer

I _____

hereby assume the responsibility of payment at the standard rate billed by Peter Forster, M.D. and Gateway Psychiatric Services for any and all medical services provided to patient

_____.

I understand that Peter Forster, M.D. and Gateway Psychiatric Services are not responsible for soliciting authorizations for any services from any insurance company with which the patient may have medical or health coverage, and further release them from any responsibility for seeking reimbursement for these services.

Therefore, any reimbursement for services from the patient's insurance company will be received through my own efforts or those of a party other than Peter Forster, M.D. and Gateway Psychiatric Services.

_____ _____

Signature of Payer Date

Relationship to patient_____

Payer's Date of Birth _____/_____/_____

Payer's Social Security Number _____ - _____- _____

Payer's Phone Number (_____) _____- _____

Payer's Mailing Address _____

_____