

MAGERS HEALTH AND WELLNESS CENTER

FINANCIAL RESPONSIBILITY FOR DEPENDENTS

Guarantor Name: _____

Guarantor Address: _____

Guarantor Phone Number: _____

Guarantor M#: _____

Guaranteed Dependent's Name: _____

Guaranteed Dependent's Date of Birth: _____

I attest that I assume financial responsibility for all charges for this dependent. I agree that these charges can go to my employee account. I also agree to notify Magers Health and Wellness Center in writing if at any time I decide I no longer choose to be financially responsible for them and will notify dependent that they are no longer eligible for services at Magers Health and Wellness Center.

Signature of Guarantor: _____ Date: _____

(To be completed by Magers Health Employee)

Witnessed By: _____ Date: _____

I attest that I am revoking financial responsibility for all charges for this dependent, effective immediately.

Signature of Guarantor: _____ Date: _____

(To be completed by Magers Health Employee)

Witnessed By: _____ Date: _____