## **Health Services Debt Assignment**

Creditor Name:					Client No.		
Address:				D	Date:		
City:	Prov: Postal Co		ode: S		Submitted by:		
The above noted party, for good and valuable cons & without recourse pursuant to our Agreement all it Services Inc.				Si	Signature:		
Send To:  Telephon Facsimile Email:							
Patient Name			SIN	DOB: mm / dd / year			
Patient Name			SIN	SIN		DOB: mm / dd / year	
* If patient is a MINOR, please	indicate <u><b>both</b></u> pa	rent names.			l		
* Emergency/Family Contact (Full name – relationship to patient & tel. no)							
Address Please indicate if mail has been returned: Yes or No							
City			Prov Postal		Postal Co	Code	
Home Tel	ne Tel Cell Tel			Work Te		l	
Email Address: Employer Info:							
Amount Owing \$	mount Owing \$ Date of Service		e 	Calculate interest @		From: mm / dd / year	
Additional information:							
			<del></del> '	ottooh	Invoice/St	atement copy for debt description.	
			* Please	allacii			
			* Please	allacri	ľ		
Patient Name			* Please	allacii	С	OB: mm / dd / year	
				attacri	С		
Patient Name	indicate <u>both</u> pa	rent names.	SIN	allacii	С	OB: mm / dd / year	
Patient Name Patient Name			SIN		С	OB: mm / dd / year	
Patient Name Patient Name * If patient is a MINOR, please			SIN SIN atient & tel. no	))	C	OB: mm / dd / year	
Patient Name Patient Name * If patient is a MINOR, please * Emergency/Family Contact			SIN SIN atient & tel. no	))	C	OB: mm / dd / year OB: mm / dd / year een returned: Yes or No	
Patient Name  Patient Name  * If patient is a MINOR, please  * Emergency/Family Contact  Address		ationship to pa	SIN SIN atient & tel. no	))	C C	OB: mm / dd / year OB: mm / dd / year een returned: Yes or No	
Patient Name  Patient Name  * If patient is a MINOR, please  * Emergency/Family Contact  Address  City	(Full name – rela	ationship to pa	SIN SIN atient & tel. no	elease ind	dicate if mail has b	OB: mm / dd / year OB: mm / dd / year een returned: Yes or No	
Patient Name  Patient Name  * If patient is a MINOR, please  * Emergency/Family Contact  Address  City  Home Tel	(Full name – rela	ationship to pa	SIN SIN atient & tel. no	lease inc	dicate if mail has b	OB: mm / dd / year OB: mm / dd / year een returned: Yes or No	

\* Please attach **Invoice/Statement** copy for debt description.