Health Services Debt Assignment

Creditor Name:			Client No.
Address:			**Date:**
City:	Prov:	Postal Code:	**Submitted by:**
The above noted party, for good and valuable consideration, receipt of which is hereby acknowledged, assigns absolutely & without recourse pursuant to our Agreement all its rights title and interest in the following debts to Credex Financial Services Inc.			**Signature:**

Send To:

CredeX FINANCIAL SERVICES INC.

Telephone: **800.263.6334**
Facsimile: **877.575.0702**
Email: clientservices@credex.ca

Patient Name	SIN	DOB: mm / dd / year
Patient Name	SIN	DOB: mm / dd / year

* *If patient is a **MINOR**, please indicate **both** parent names.*

* ***Emergency/Family Contact*** *(Full name – relationship to patient & tel. no)*

Address	Please **indicate** if mail has been returned : **Yes** ◯ or **No** ◯	
City	Prov	Postal Code
Home Tel	Cell Tel	Work Tel
Email Address:	Employer Info:	

Amount Owing $	**Date of Service**	Calculate interest @	From: mm / dd / year

Additional information:

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

Patient Name	SIN	DOB: mm / dd / year
Patient Name	SIN	DOB: mm / dd / year

* *If patient is a **MINOR**, please indicate **both** parent names.*

* ***Emergency/Family Contact*** *(Full name – relationship to patient & tel. no)*

Address	Please **indicate** if mail has been returned : **Yes** ◯ or **No** ◯	
City	Prov	Postal Code
Home Tel	Cell Tel	Work Tel
Email Address:	Employer Info:	

Amount Owing $	**Date of Service**	Calculate interest @	From: mm / dd / year

Additional information:

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

Debt Recovery Is Our Business.