

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:



Telephone: 800.263.6334
Facsimile: 877.575.0702
Email: collections@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.			

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