ST JOHN'S MILITARY SCHOOL

SJMS.ORG
P.O. BOX 5020
SALINA, KS 67402-5020
785•823•7231
fax 785•823•2701

AUTHORIZATION FOR PAYMENT OF PRESCRIPTION AND MEDICAL SERVICES

Cadet Information

Last Name _____ First _____ MI _____

Date of Birth _____ Date _____

Insurance Payment Agreement

The undersigned hereby agrees to the following:

Whereas St. John's Military School uses the services of various health care providers (Service Provider(s)); Whereas the Service Provider(s), at the insured's request & as a courtesy to the insured, have agreed to bill the insured's company for prescribed medication, medical related items, and services prescribed by the insured's physician and accept assignment on the anticipated insurance payment.

I hereby authorize the Service Provider(s) to directly receive payment for all purchases and to give the necessary information to receive such payment.

I also hereby agree that if the insurance company makes payment directly to me, to remit that sum immediately to the Service Provider(s).

I understand that a reasonable effort will be made to notify me prior to any charges being assessed, but notification notwithstanding, I acknowledge final responsibility for the prescription medication, supplies and services provided and agree to pay the deductible amount and any other amounts that the insurance company does not pay the Service Provider(s), and I understand that the Service Provider(s) will bill me for the balance.

Signature of Insured/Responsible Party _____ Date _____

Insurance must cover emergency care.

Debit or Credit Card Information

☐ VISA ☐Discover ☐ Master Card ☐ American Express

Credit Card Number _____

Expiration Date _____ CVS Security Code _____

Name on Card (print) _____

Billing address (if different than mailing address) _____

I agree to pay via this debit/credit card for all services provided.

Signature _____ Date _____

The above information is required.