Client Billing Information

Full Name: _____
Date of Birth: _____
Gender: _____
Address: _____
Phone Number: _____
Email: _____

Responsible Party for Billing (if different from client)

Full Name: _____
Relationship to Client: _____
Address: _____
Phone Number: _____
Email: _____

Insurance Information

Primary Insurance Provider: _____
Policy Number: _____
Group Number: _____
Insurance Phone Number: _____
Insurance Address: _____
Secondary Insurance Provider (if applicable): _____
Policy Number: _____
Group Number: _____
Insurance Phone Number: _____
Insurance Address: _____

Billing Preferences

Preferred Method of Payment:

- Credit/Debit Card: [ ]
- Cashiers Check: [ ]
- Bank Transfer: [ ]
- Other: _____

Billing Cycle:

This form is confidential and will be used solely for the purpose of billing and payment for services rendered by Paramount Home Care Services, LLC.

Monthly: [ ]
Bi-weekly: [ ]
Weekly: [ ]

Preferred Method of Receiving Invoices:

Email: [ ]
Postal Mail: [ ]

Payment Information (for Credit/Debit Card)

Cardholder Name: _____
Card Number: _____
Expiration Date (MM/YY): _____
CVV: _____
Billing Address: _____

Payment Information (for Bank Transfer)

Account Holder Name: _____
Bank Name: _____
Routing Number: _____
Account Number: _____
Billing Address: _____

Authorization and Agreement

I, the undersigned, authorize Paramount Home Care Services, LLC to bill me or the responsible party listed above for services rendered. I understand that payment is due according to the terms stated in the service agreement and any applicable late fees as outlined in the agency's late fee policy.

I agree to notify Paramount Home Care Services, LLC of any changes to my billing information or payment method.

Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____

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