

Acceptance of Financial Responsibility for Medical Services

We, the undersigned prospective adoptive parent(s), hereby accept responsibility for all medical bills relating to the birth of the child we are adopting, including all medical bills for the natural mother related to the pregnancy and/or birth.

We understand that Adoption Team Hawaii, Inc., will provide my/our name(s), address and telephone numbers to all providers of medical services, so that such providers may bill us directly.

We understand that by execution of this Acceptance of Financial Responsibility for Medical Services, we are authorizing the release of the following information necessary to process any claims related to the birth of our child:

Name of Person(s) Financially Responsible:

\_\_\_\_\_

Billing Address:

\_\_\_\_\_

Telephone Number(s):

Home: \_\_\_\_\_ Work: \_\_\_\_\_

Social Security Number(s):

Male (if applicable): \_\_\_\_\_ Female: \_\_\_\_\_

Name of Medical Insurance Company:

\_\_\_\_\_

Name of Insured:

Policy / I.D. #

\_\_\_\_\_

Address for Claims Department:

\_\_\_\_\_

Telephone Number (including area code) for Claims:

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_