EAST COOPER COMMUNITY OUTREACH

Declaration of Insurance Status

Dental Clinic · Prescription Assistance · Medical Clinic

I, _____ (Print Name)

☐ I declare that **I DO** have insurance (Medicaid, Medicare or Private Insurance)

☐ I declare that **I DO NOT** have insurance ~~or~~ I am unable to pay for dental services

☐ I declare that **I DO NOT** have insurance coverage through any of the following:

- Medicaid
- Medicare
- Private Insurance Company (Ex. Blue Cross)

I understand the health services provided are for individuals who are uninsured. If I obtain insurance or other medical care it is my responsibility to notify Medical Clinic, Prescription Assistance, and/or the Dental Clinic within 7 business days. I understand if I withhold or falsify information regarding insurance coverage that I will be released from all health services at ECCO.

Client Signature _____ Date _____

Disclaimer: East Cooper Community Outreach has the right to confirm and follow up on all information provided during the eligibility verification process. Providing false information may disqualify a person from recieveing services. Additionally, completing this process does not guarantee services.