



BILLING INFO

Resident's Name: _____ Date of Birth: _____

Monthly Rate: \$ _____ Admission Date: _____

Person Responsible for Payment _____ Relationship: _____

Payment Type: ☐ Credit/Debit Card ☐ Check ☐ Electronic (Zelle)

Billing Address: _____

City State Zip Code
Phone #: _____ Fax #: _____

Send all correspondence to the above address? ☐ Yes ☐ No

If no, please indicate where to mail other correspondence.

Address

City State Zip Code

I, the above party, attest that I am solely responsible for the monthly service payments and applicable taxes and fees to the Assisted Living Facility. I acknowledge and accept payments using credit or debit account incurs processing fees up to 4% per transaction. I also understand and accept responsibility for proper and timely payment. I have received a copy of the signed lease agreement which outlines applicable fees, amendments, modifications, refunds, and termination provisions.

Resident/Representative/POA

Date

Facility Representative

Date