# PATIENT INFORMATION AND PAYMENT AGREEMENT

**Telephone: 951-808-8863 Fax: 951-808-0550 www.pathcarefna.com**

1810 Fullerton Avenue, Suite 102
Corona, CA 92881

41900 Winchester Road, Suite 100
Temecula, CA 92590

17451 Bastanchury Road, Suite 104C
Yorba Linda, CA 92886

## PATIENT INFORMATION

| LAST NAME | FIRST NAME | INITIAL | DOB | GENDER |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| NAME OF PERSON LEGALLY RESPONSIBLE (IF PATIENT IS MINOR) | MARITAL STATUS |
| HOME ADDRESS | HOME /CELL PHONE |

| | | |
|---|---|---|
| SSN | DRIVERS LICENSE NUMBER | OCCUPATION |
| EMPLOYED BY | BUSINESS ADDRESS | WORK PHONE |
| EMERGENCY CONTACT PERSON | CONTACT PERSON'S PHONE | RELATIONSHIP TO CONTACT PERSON |
| REFERRED BY | PRIMARY CARE PHYSICIAN | PCP PHONE |

## INSURANCE INFORMAITON

| PRIMARY INSURANCE COMPANY | SECONDARY INSURANCE COMPANY |
|---|---|
| POLICY/GROUP NUMBER | POLICY/GROUP NUMBER |
| INSURED NAME | INSURED NAME |
| EFFECTIVE DATE | EFFECTIVE DATE |

### ASSIGNMENT OF BENEFITS:

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits to which I am entitled to PathCare Diagnostics Inc. for any services rendered to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.
This assignment will remain effective until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

_____ _____

DATE SIGNATURE OF PATIENT (OR LEGAL GUADIAN)

_____

WITNESS