



PATIENT INFORMATION AND PAYMENT AGREEMENT

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Yorba Linda, CA 92886

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DOB	GENDER
NAME OF PERSON LEGALLY RESPONSIBLE (IF PATIENT IS MINOR)			MARITAL STATUS	
HOME ADDRESS			HOME OR CELL PHONE NUMBER	
E-MAIL ADDRESS	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 INFORMATION

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 I revoke 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 unpaid by the said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN)

DATE

WITNESS