South Valley Pharmacy Services

Identification and Guarantor Information

Patient Information

Patient Name:	Social Security Number:	Date of Birth:	Age:	Sex:

Facility Name (if applicable):	Address:	City:	Zip Code:	Telephone:

Date of Admission:	Address Prior to Admission:	City:	State and Zip Code:	Telephone:

Emergency Contact Information

Name:	Relationship:	Address:	Telephone:
Name:	Relationship:	Address:	Telephone:
Name:	Relationship:	Address:	Telephone:

Financially Responsible Party/Guarantor Information

Name:	Address:	City	State:	Zip Code:	Telephone:

Credit Card Number (Visa, Mastercard, AMEX):	CVV Code:	Expiration Date:

Financially Responsible Party/Guarantor Disclaimer

I assign and authorize direct payment to South Valley Pharmacy Services of all insurance and health plan benefits payable for these pharmacy services. I agree that the insurer or plans payment to the pharmacy pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I understand that if no payment is received by myself, the financially responsible party, within **30 days** of services rendered the credit card on file will be charged the full balance due.

Signature of Financially Responsible Party:	**Date:**

Physician Information

Physician Name:	Address:	City:	Sate:	Zip:	Telephone:
Physician Name:	Address:	City:	Sate:	Zip:	Telephone:

Required Signatures

Signature of Responsible Party:	Signature of Person Completing Form:	Date:

Please provide a copy of the medication list as well as any insurance cards.

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Fax: (408) 847-7878