POTOMAC RIVER CLINIC

CONTACT INFORMATION

Date: _____

Child's information
Name:
Mailing address:
Home phone number:
Parent/Caregiver's contact information
Name:
Address (if different from above):
Employed by:
Home phone number:
Work phone number:
Cell phone number:
Email address:
Parent/Caregiver's contact information
Name:
Address (if different from above):
Employed by:
Home phone number:
Work phone number:
Cell phone number:
Email address:

POTOMAC RIVER CLINIC

CREDIT CARD PAYMENT INFORMATION

I hereby authorize Potomac River Clinic to charge my credit card for the purpose of all services rendered and equipment on behalf of myself or my child, _____.

I understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction.

I understand that this agreement is between myself and Potomac River Clinic.

Name as it appears on card: _____

Type of Card: (circle one) VISA MASTER CARD

Account Number: _____

Expiration Date: _____

CVT CODE (3-digit security code/back of the card): _____

Cardholder Signature: _____

Credit Card billing address: _____

_____

Telephone number: _____

Today's Date: _____

POTOMAC RIVER CLINIC

INSURANCE INFORMATION

Client's Name: _____ Date of Birth: _____ Gender: _____

INSURANCE	PRIMARY	SECONDARY
Company Name:		
Subscriber's Name:		
Subscriber's Date of Birth:		
Insurance Mailing Address:		
Member ID #:		
Group #:		
Provider's Phone #:		

****** PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD**

Please read carefully and sign below.

I authorize Potomac River Clinic to bill directly my/our insurance for services and/or durable medical equipment (DME) rendered. I understand that if an insurance payment is not received within 90 days of billing, Potomac River Clinic will bill me for the amount, which will become due immediately. If after I pay the charges and an insurance payment is received at a later date, Potomac River Clinic will credit my account and issue a refund. I understand that, under certain circumstances, therapy may be suspended until an overdue account is settled.

Signature of Client or Parent/Guardian: _____

Name (print): _____

Date: _____

Office Use Only:
Rep: _____
Comments: _____
_____
_____
_____
Initials: _____