



## South Valley Pharmacy Services

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### 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 <b>30 days</b> 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:	
<b>Please provide a copy of the medication list as well as any insurance cards.</b>						

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