Account Update Form

Clinician & Billing Information

Please complete this form and return it to Qliance Member Services. You may fax this form to (206) 381-3035 or mail it to 2101 Fourth Avenue, Suite 600, Seattle, WA 98121. Upon receipt, we will process your new information and send you confirmation of the change.

Patient information

Last name	First name	MI	DOB	☐ Male	☐ Female
Home address:	City:	State:	ZIP:		
Billing address:	City:	State:	ZIP:		
Phone #1: ( ) O Home O Work O Cell	Phone #2: ( ) O Home O Work O Cell				
Email address:					
Emergency contact:	Phone: ( )	Relationship:			

Change of Clinician

Current clinician:
New clinician:
**This change will take effect on the first day of your next billing cycle. If you have selected a clinician of another service level, please note your account will reflect the corresponding change in price level. For questions, please contact Qliance member services at (206) 381-3030.*

Billing Preferences

Billing Frequency: O Monthly O Quarterly O Semi-Annually O Annually		
OPTION A: Credit Card or Debit Card		
Name on card:		
Card type: O Visa O MasterCard O American Express	Card number:	Expiration:
Card billing address: ☐ *Same as home.*		3-digit code
☐ *Yes, please add me to the billing account of an existing Qliance patient associated with the above credit card.*		
OPTION B: Automatic Funds Transfer		
Name on account:		
Bank name:	Account type: O Checking O Savings	
Account number:	Bank routing number: *(please attach a voided check to this form)*	

Authorization

Your monthly care fee covers the services described in the Qliance Patient Services Guide. At times, however, your care may require durable medical supplies or third-party services that are not covered by your monthly care fee. To streamline your appointment check-out, please note that by providing the above billing information you authorize Qliance to automatically charge your card or draw on your bank account for any incidental items at the time of service. In all cases, incidental items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Qliance to contact me using the information I have provided above. By signing below, I hereby authorize Qliance to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Qliance has received written notification from me of its termination in such time and in such manner as to afford Qliance and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in Qliance is continuous and that, by signing below, I authorize recurring credit/debit card charges.
- I understand and that a $25 fee will be charged to me for declined credit or debit card transactions that are not honored.

ACCOUNT HOLDER SIGNATURE: DATE:

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