



## SERVICE CANCELLATION FORM

Upon completion, please fax this form to the Qliance Member Services at (206) 381-3035 or mail it to 999 Third Avenue, Suite 810, Seattle, WA, 98104.

PATIENT INFORMATION					
Last name	First name	MI	DOB	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Home address:			City:	State:	ZIP:
Billing address:			City:	State:	ZIP:
Phone #1: ( )	<input type="radio"/> Home	<input type="radio"/> Work	<input type="radio"/> Cell	Phone #2: ( )	<input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell

ACCOUNT INFORMATION
Patient number (if known):
Billing account number (if known):
Clinician name:

MEMBERSHIP CANCELLATION
<b>Today's Date:</b>
Service cancellation is effective on the last day of your current billing cycle unless otherwise specified: <i>Please note that the earliest effective cancellation date is the date Qliance receives this form.</i>
I am cancelling my Qliance membership because:
<input type="checkbox"/> Deceased <input type="checkbox"/> Job related (insurance provided by employer) <input type="checkbox"/> Financial considerations
<input type="checkbox"/> Dissatisfied with service <input type="checkbox"/> Moving out of the area
<input type="checkbox"/> Other, please specify:

AUTHORIZATION
I am choosing to cancel my Qliance patient membership. As per the <i>Qliance Patient Services Agreement</i> .
<ul style="list-style-type: none"><li>• I understand that my current monthly care fee payment entitles me to receive Qliance services until the end of the current pay period.</li><li>• I understand that if I have made any pre-payments beyond the current monthly service period, they will be pro-rated to the date of cancellation and refunded to me within ten (10) business days.</li><li>• I understand that at any time from this day forward, I may request a copy of my patient medical record for myself or on behalf of another physician or individual.</li><li>• I understand that as of the end of my membership, I will not be able to access any of the services offered by Qliance.</li><li>• I understand that I may re-join Qliance Medical Group at any time under the terms and conditions for registration at that time.</li></ul>
<b>SIGNATURE:</b> _____ <b>DATE:</b> _____
<b>PRINT NAME:</b> _____ <b>SIGNATURE BY:</b> <input type="radio"/> Patient <input type="radio"/> Parent <input type="radio"/> Legal Guardian