



Service Cancellation Form

Upon completion, please fax this form to the Qliance Member Services at (206) 381-3035 or mail it to 2101 Fourth Avenue, Suite 600 Seattle, WA 98121

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):	Clinician name:
Billing account number (if known):	Billing date:

Membership Cancellation

Service cancellation is effective on the last day of your current billing cycle unless otherwise specified.

Please note that the earliest effective cancellation date is the date Qliance receives this form.

I am cancelling my Qliance membership because:

Moving out of area

Dissatisfied with service

Job related (insurance provided by employer)

Financial Considerations

Transferring care

Other, please explain:

Authorization

I am choosing to cancel my Qliance patient membership. As per the *Qliance Patient Services Agreement*:

- I understand that my current monthly care fee payment entitles me to receive Qliance services until the end of the current pay period.
- 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.
- 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.
- I understand that as of the end of my membership, I will not be able to access any of the services offered by Qliance.
- I understand that I may re-join Qliance Medical Group at any time under the terms and conditions for registration at that time.
- I understand that a re-registration fee will be applied to my account if I choose to re-start my Qliance membership at a future date.

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

SIGNATURE BY: Patient Parent Legal Guardian