Amera Account Profile

New Client: ☐ Prior Client: ☐
Date Form Completed: _____

Client Information

Name of Company or Facility: _____
Primary Telephone:_____2nd Telephone: _____
Client Full Name(s): _____
Clients Address: _____
Clients Email: _____

Medical Service Type: Sedan ☐ Wheelchair Van ☐ Ambulance ☐ Air Ambulance ☐
Professional Medical Attendant ☐ Medical Travel Arrangements ☐

Billing Information

Responsible Party's Full Name:
_____
AMEX [ ] Discover [ ] MasterCard [ ] Visa [ ]:
Card #_____
Expiration Date: _____Security Code: _____
Billing Address: _____State: _____Zip Code: _____

Referred by: Online ☐ Medical Facility ☐ Attorney ☐ Other ☐

Please provide any information to help Amera service any special request for this account:

_____

_____

_____

Clients Approval Signature: _____ Date: _____

FOR AMERA OFFICE USE ONLY

Fill out the following items when account is approved:

- Client Account #:_____
- 30 Day Net: YES [ ] NO [ ]
- Workers Comp YES [ ] NO [ ]
- Credit Card Form Completed: YES [ ] NO [ ]
- Referral Form Submitted: YES [ ] NO [ ]