PROVIDER NAME	REFERRED BY	PT ACCOUNT #	DIAGNOSIS

PATIENT: Please complete all information. please print clearly

FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	MARITAL STATUS M S D W

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	SOCIAL SECURITY NUMBER	DATE OF BIRTH
( )	( )		

EMPLOYER	Cell Number

EMPLOYER'S ADDRESS

NAME OF NEAREST RELATIVE (not living with you)	RELATIONSHIP	PHONE NUMBER
		( )

E-MAIL ADDRESS	MOBILE

RESPONSIBLE PARTY INFORMATION (if not patient)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	MARITAL STATUS M S D W

ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBE R	DATE OF BIRTH	HOME PHONE	WORK PHONE
		( )	( )

EMPLOYER	EMPLOYER'S ADDRESS	OCCUPAiION

E-MAIL ADDRESS	: MOBILE

INSURANCE INFORMATION: (including Medicare)

INSURANCE COMPANY #1	POLICY NUMBER	GROUP NUMBER

INSURANCE ADDRESS	PHONE NUMBER
	( )

INSURED'S NAME	RELATION TO PATIENT	DATE OF BIRTH	SEX

INSURANCE COMPANY #2	SOCIAL SECURITY NUMBER	GROUP NUMBER

INSURANCE ADDRESS	PHONE NUMBER
	( )

INSURED'S NAME	RELATION TO PATIENT	DATE OF BIRTH	SEX

IN CASE OF EMERGENCY:

NAME	PHONE
	( )

ADDRESS

I, ***the undersigned, give permission to release information to 3rd party carrier(s)*** and do assign ***all insurance benefits for treatment to*** be paid ***directly*** to ***the*** above named ***provider*** and ***request that this*** assignment ***remain*** on ***file with*** my ***insurance carrier.*** I ***certify that*** a ***copy*** of ***this assignment shall*** be as ***valid*** as the ***original.***

I, the ***undersigned*** recognize that the ***provider*** cannot accept ***responsibility*** for ***collecting any*** i***nsurance claim*** or ***negotiating any settlement*** on a ***disputed*** claim. I ***also*** agree that ***in the*** event of default ***in the*** payment of any amount due, and if this account is placed ***in*** the ***hands*** of an agency or ***attorney for collection*** or legal action, to pay up ***to*** an ***additional 50%*** of cost of ***collection including agency*** and ***attorney fees*** and ***court costs incurred*** and ***permitted*** by ***laws governing these transactions.*** A ***finance charge*** of 1.5 ***percent*** per month ***(annual rate*** of 18 ***percent) will*** be charged on ***all balances over*** 30 ***days, regardless*** of pending ***insurance claims.***

Date

Signature of responsible party