INTEGRATED MEDICAL GROUP

Authorization and Assignment Notice

PATIENT INFORMATION

_____ _____ _____
Last Name **First Name** **Middle Initial**

_____ / _____ / _____ **M / F** _____ _____ - _____ - _____
Date of Birth **Gender** *(circle one)* **Age** **Social Security #**

_____ _____ _____ _____
Street Address **City** **State** **Zip**

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
Home Phone **Work Phone** **Cell Phone**

_____
Email Address

Confidential Communication Preference (circle one): Home - Work - Cell - Email - Postal Service

Marital Status *(circle one):*
Single - Married - Widowed - Divorced - Partnered - Other

Ethnicity *(circle one)*
Non-Hispanic/Latino - Hispanic/Latino

Race *(circle one):*
Caucasian - African American - American Indian - Native Alaskan - Native Hawaiian - Other Pacific Islander - Asian - Other

Preferred Language: _____

Smoking Status *(circle one)*: Current Every Day Smoker - Current Some Day Smoker - Former Smoker - Never Smoker

INSURANCE INFORMATION

Primary: _____ Secondary Insurance: _____

Insured Information: *(Must be completed if the patient is not the insured member.)*

_____ _____ _____
Last Name **First Name** **Middle Initial**

_____ / _____ / _____ _____ _____ - _____ - _____
Date of Birth **Age** **Social Security #**

_____ _____ _____ _____
Street Address **City** **State** **Zip**

REFERRAL INFORMATION

Who can we thank for referring you? *(circle one and enter name)*

Phone Book - Doctor / Care Provider - Friend / Family - Other: _____

Name of person giving referral: _____

MEDICATIONS

☐ *Please mark if you currently take no medications.*

Name of Medicine	Generic / Brand	Strength	Dose	Frequency	How Taken	Start Date
Example: Lasix	*Furosemide*	*20 mg*	*1*	*Daily*	*Orally*	*5/4/2010*

ALLERGIES

☐ *Please mark if you have no known allergies.*

_____

_____

AUTHORIZATIONS AND ASSIGNMENT

a. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

b. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.

c. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for you services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under "Pertinent Data") and authorize you to prosecute said action in my name as you see fit. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe to your office.

d. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Integrated Medical Group, Ltd. are paid in full.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature Date