

WELCOME TO OUR OFFICE
INTEGRATED MEDICAL GROUP, LTD.

Patient Information

Last Name	First	MI	Date of Birth	Age	<u>M / F</u> Sex
Street Address	City		State	Zip	
Home Phone	Work/Cell Phone	Email	SSN		
<u>Single / Married / Other</u> Marital Status	<u>Employed / Retired / Student / Other</u> Employment Status		How Did You Hear About Our Office?		
Person to contact in case of emergency		Relationship	Phone #		
Primary Care Physican	Address		Phone #		

Insurance Information

Primary Insurance	Group # / Policy #	ID #	Customer Service/Eligibility Phone
Secondary Insurance	Group # / Policy #	ID #	Customer Service/Eligibility Phone

Insurance Holder Information

Name	Address	Phone
Relationship to Patient	Date of Birth	SSN
		<u>M / F</u> Sex
Employer Name	Employer Address	

AUTHORIZATIONS:

- 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 assignments.
- 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 of 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, up on 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 your 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 either in my name as you see fit and 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 you.
- D. I further agree that this Authorization and Assignment is irrevocable until all monies owed Dr. David Thayer and Integrated Medical Group are paid in full.

Patient Signature	Date
Guardian Signature	Relationship to Patient
	Date