Patient Information & Assignment of Benefits

Patient Name ______________________ Sex: ❑ Male ❑ Female

Birth Date ____________ SSN ____________ Marital Status ____________

Cell Phone ____________ Work Phone ____________ Home Phone ____________

Address ______________________ Apt.# ____________

City ____________ State ____________ Zip ____________

Parent/Guardian (if Minor) ____________ Parent/Guardian DOB ____________ Phone ____________

Address ____________ City ____________ State ________ Zip ________

Emergency Contact: ____________ Relationship: ____________ Phone ____________

Referring Doctor Name ______________________ Phone ____________

❑ **SELF-PAY / NO INSURANCE / CORPORATE ACCOUNT**

❑ **PRIMARY Insurance Co Name** ______________________ Phone ____________

Policyholder ______________________ DOB ____________ SSN ____________

Policyholder's Employer ______________________

Insurance ID ____________ Group # ____________ Relation to Insured: ____________

❑ **SECONDARY Insurance Co Name** ______________________ Phone ____________

Policyholder ______________________ DOB ____________ SSN ____________

Policyholder's Employer ______________________

Insurance ID ____________ Group # ____________ Relation to Insured: ____________

❑ **WORKERS COMPENSATION**

Claim # ______________________ **Accident date:** ____________

Where accident occurred: ______________________

Employer Name ______________________ Phone ____________

❑ **PERSONAL INJURY (with Attorney Letter of Protection)**

❑ Auto ❑ Other ______________________ **Accident date:** ____________

Attorney: ______________________

Assignment of benefits: I hereby irrevocably assign to HMRI and any practitioner providing medical care and treatment to me, any and all benefits and all interest and rights (including causes of action and the right to enforce payment) under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from any other payer providing benefits on my behalf for and to the extent of the services and goods provided to me. Under this assignment, HMRI shall have an independent, non-exclusive right to appeal or pursue any denied or delayed claims on behalf on the insured or beneficiary. This assignment is not and shall not be construed as an obligation of HMRI and/or affiliated practitioners, such interest and rights. In signing this form, I (as the patient or patient's agent) am directing any applicable health insurer, health benefit plan, indemnity plan, reinsurer, third-party liability insurer or other payer providing benefits on my behalf to pay HMRI and/or affiliated practitioners for the services and goods provided to me.

______________________ ____________ ____________

Print & Signature of Patient / Guardian / Authorized Representative **Relationship to Patient** **Date**