Patient Information

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Name _____ Phone _____

Email _____ Address _____

City _____ State _____ Zip _____ Age _____ Birth Date _____

RACE _____ ETHNICITY _____

GENDER _____ HEIGHT _____ WEIGHT _____

Marital Status (Circle One): **S M W D** Sep Children _____

Insured Name _____ Insured Birthdate _____

How did you find out about our office? _____

_____

Is your condition due to an accident? ☐ Yes ☐ No Date of your accident:

Please describe your current complaint. In other words, what brought you in to see us?

_____

_____

_____

ASSIGNMENT OF BENEFITS
-IRREVOCABLE-

In consideration of your undertaking to render care, I agree to the following:

Release of Information
You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

Right to Receive Payment
I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft or check containing my name to which you are legally entitled.

Assignment of Right to Sue
1. In the event any insurance company or attorney, obligated by contractual agreement to issue payments to me for your service charges, refuses to pay upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
2. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.
3. I waive the Statue of Limitations regarding my doctor's right to recover from me directly
4. I hereby direct my attorney to cooperate, assist and not interfere with you, the medical provider, in recovering any MedPay benefits that I may be entitled to.

DATE _____

PATIENT SIGNATURE _____

MEDICAL PROVIDER: MARK J. GLESENER, DC