REGISTRATION

FULL NAME | BIRTH DATE | DATE

SGLE MAR WID DIV CHILD | SOCIAL SECURITY NO.

HOME ADDRESS

CITY | STATE | ZIP

HOME PHONE | CELL #

OCCUPATION | EMPLOYER

EMPLOYER'S ADDRESS | PHONE

NAME OF SPOUSE OR PARENT | PHONE

OCCUPATION OF SPOUSE | EMPLOYER OF SPOUSE

EMPLOYER'S ADDRESS | PHONE

RESPONSIBLE PARTY | PHONE

ADDRESS

MEDICAL INSURANCE-COMPANY

GROUP NO. | POLICY NO.

INSURED'S NAME

INSURED'S DATE OF BIRTH

OTHER HEALTH INS.

GROUP NO. | POLICY NO.

NOTIFY IN AN EMERGENCY OTHER THAN ABOVE:

PHONE

PATIENT REFERRED BY:

AUTHORIZATION

I, the undersigned, do hereby request and give my consent for any physician associated with the Internal Medicine Clinic to release to my insurance company/companies any protected health information necessary for treatment, payment or health care operations to the application of my insurance claim. I understand this consent may be revoked by me, in writing, at any time.

I, the undersigned, do hereby request that all benefits payable for medical services rendered be paid directly to the Internal Medicine Clinic.

I understand that I am financially responsible to you for all of my individual charges incurred during the course of your treatment, including hospitalization, even though I may have insurance or other third-party coverage. I recognize that the cost of this medical care may exceed the amount reimbursed by my insurance company. I understand that I will be expected to pay the amount set forth on the physicians fee schedule regardless of what my insurance company may consider usual and customary. (Exception is noted for medicare and all PPO contracts) I promise to pay this amount when due. In the event of default, I recognize that legal proceedings may result and I agree to pay all cost of collection including reasonable attorney's fees.

A photostatic copy of this consent and assignment shall be considered as effective and valid as the original, and I do hereby consent for duplication of the original whenever necessary for insurance purposes.

I, the undersigned, do hereby acknowledge that I have a complete understanding of the contents herein and that my signature below makes this a valid and legal document.

SIGNATURE

Patient

Insured (if other than the patient)

DATE