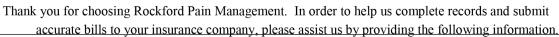
Patient Information





Today's date First Name		_ Last Name	
Nick-name preferred:			
Date of Birth		Soc. Sec # _	
Mailing Address			
City			
			Work Phone
		Occupation	
Were you referred by [☐ Friend ☐ Insurance (Carrier Physic	cian ☐ Phone Book ☐ Advertise Workshop: ☐ Knee ☐ Fibro ☐ F
Referral Source?			
			Phone #
			man's Comp. Injury ☐ Persona
ou seeing the doctor of		ident worki	man's comp. mjury1 crsona
		ance Patients	
D -1 - (' 1 1 1 1 1	Primary Insurance	1 🗆 - 4	Secondary Insurance
			☐ self ☐ spouse ☐ child ☐ other N is other than SELF.
Insured's Name:	ig msureu miormano	JII II K <i>ELATIO</i>	V is other than SELF.
Insured's Birthdate:			
Insured's Ins. ID:			
Group Number:			
Benefits Phone #:			
agnose and treat my conditus provider and also authorized for agent. I designate for Attorney in insurance related, collection fees or other eaccept a copy of this releate in writing. I designate Sonder the Employee Retirem to act on my behalf to pursuits.	tion(s). Further I authorize a ize the release of such infor- e this provider, practice, and ethic provider. I understand the expenses incurred by the pro- se and assignment in lieu of CPC and agent (here after re- ent Income Security Act of- ue claims and exercise all re- dical or other health care ex- is include the right to act on	assignment of my in rmation as needed d agent as Authoriz nat I am responsible rovider in collecting of the original. This referred to as my do 1974 ("ERISA") an rights connected wi expense(s) incurred a my behalf with res	deemed necessary by the physician to nsurance rights and benefits directly to to process insurance claims by zed Representative with Durable Power of for all charges which may include legal my account. I hereby order all parties shall remain in effect until revoked by octor), to the full extent permissible and as provided in 29 CFR 2560-503-1(b) ith my employee health care benefit as a result of the services I received pect to initial determinations of claims, and to claim on my behalf such
om my doctor. These rights pursue appeals of benefit			bursement and to pursue any other

Office Use: F/C: INS

MC

MD

IO WC

Atchd: Insurance Card Claim Form Referral

PI SP

CCC#

Event: _

AA