REFERRED BY:

(Please Circle One) PHYSICIAN FRIEND TELEPHONE AD NEWSPAPER AD

If a physician or friend referred you to us, please give us their name so that we may thank them.

_____

Please READ and SIGN the following authorization and assignment to be kept on file in the event of hospitalization, surgery, or any other professional services rendered OUTSIDE of our office which you would request an insurance claim to be filed for you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize IVhealth center to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature:_____

Insured's Signature:_____

A photocopy of this authorization and assignment shall be considered as valid as the original.

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION

Mother's Name:_____ Phone: ( )_____

Address: _____ City/State/Zip:_____

Employer:_____ Address:_____

Employer's Phone: ( )_____

Father's Name: _____ Phone: ( )_____

Address:_____ City/State/Zip:_____

Employer:_____ Address:_____

Employer's Phone: ( ) _____