

Assignment of Benefits Authorization / Release Form

Patient's Full Legal Name: _____ Preferred: _____ Maiden Name: _____
Date of Birth: _____ Age: ____ Sex: M / F SSN: _____ Race: _____ Ethnicity: _____
Marital Status: M / S / D Driver's License State/#: _____ Primary Language: _____ Religion: _____
Address: _____ City: _____ State: ____ Zip: _____ County: _____
Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____ Use for Primary: Hm / Wk / Cell
Email Address: _____
Employer: _____ Position: _____
Parent or Spouse Name: _____ Insured Party Y / N SSN: _____ Date of Birth: _____
Work Number: (____) _____ Cell: (____) _____ Parent or Spouse's Employer: _____
Emergency Contact : _____ Relationship: _____ Home/Cell: (____) _____
Pharmacy Name/Phone: 1) _____ 2) _____
Patient's Primary Care Dr: _____ Phone Number: _____ Date Last Seen: _____
How did you hear about us? Radio / Friend / Family / Existing Patient / Internet / Physician / Expo / Other: _____

ALL FEES PAYABLE AT TIME OF SERVICE UNLESS SPECIAL ARRANGEMENTS ARE MADE.

RELEASE OF MEDICAL RECORDS/LAB/IMAGING: I authorize the release of any and all information/records/x-rays, etc. needed to evaluate my condition. I further request that this and any other pertinent information be forwarded to Progressive Medical Centers of America, 4646 North Shallowford Rd, Suite 100, Atlanta, GA 30338.

REQUEST FOR MEDICAL CARE: I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment of myself, my spouse or my minor children/dependent listed above. I consent to Progressive owning the copyright to any testimonies I release to the internet. I consent to any matter that involves the medical board of Georgia.

RELEASE OF FINANCIAL INFORMATION: I hereby authorize Progressive Medical Centers of America and/or its assigns all rights necessary to obtain financial information on me or my spouse in order to make determinations of my credit worthiness. Additionally I authorize Progressive Medical Centers of America and or its assigns to obtain a pre-approval for credit on services or treatments that I may or may not elect to utilize.

DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS: By way of original or a copy hereof, I, the undersigned patient hereby direct my insurance carrier to make payment directly to PMC Medical of America, PC, Viktor Bouquette, MD, Joann Donaldson, MD, Frank Matalone, DO for services rendered on my behalf. Additionally, I hereby authorize my insurance carrier to make any and all checks out to PMC Medical of America, PC, Viktor Bouquette, MD, Joann Donaldson, MD, Frank Matalone, DO. This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company for services and treatment that I receive from Progressive Medical Centers of America et al and all rights to proceed against my insurance company in any action, including legal suit, if for any reason, my insurance company fails to make payment which I am due. I fully agree, understand, that I am responsible for any/all charges not paid by my insurance company. Furthermore, this direct payment authorization with assignment of benefits transfers no right, title or interest in said contract other than the right to receive direct payments and as specified hereinabove. I also authorize Progressive Medical Centers of America et al to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I further agree that should I directly receive any insurance checks for services rendered by Progressive Medical Centers of America et al, I shall immediately endorse and forward these checks to Progressive Medical Centers of America, as I have no claim to these checks.

Patient/Authorized Person Signature

Witness

Date