CHICAGO ANTI-AGING INSTITUTE

Welcome and thank you for choosing the **Chicago Anti-Aging Institute**. The following information is necessary for our office to serve you with complete, accurate and seamless billing to your insurance company, carrier or attorney. If you need help please ask the receptionist.

NEW PATIENT INFORMATION

Patient Name: First _____ Initial_____ Last _____

Street Address _____ City_____ State_____ Zip_____

Birth Date _____ /_____ /_____ Age _____ Sex:❑ male ❑ female Soc. Sec.# _____ - ____ - _____
❑ Single ❑ Married ❑ Widowed ❑ Divorced

Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

Email Address: _____ Employer _____

How did you hear about our office? ❑ Newspaper _____ ❑ TV _____ ❑ Radio_____
(which newspaper) (channel) (station)
❑ Lecture ❑ Health fair ❑ Web site ❑ Yellow Pages ❑ Business invitation card ❑ Other_____
❑ Patient referral _____❑ Physician referral_____
(patient's name) (physician's name)

Complete the following information and present your insurance cards to the receptionist

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured	❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Name		
Insured Birthdate		
Insured Insurance ID#		
Insured Policy#		
Male / Female	❑ Male ❑ Female	❑ Male ❑ Female
Employer		

WORKMANS' COMPENSATION OR AUTO ACCIDENT CLAIM FILING INFORMATION	
WORKMANS' COMPENSATION / AUTO INSURANCE	YOUR ATTORNEY'S INFORMATION
Date of Injury / Accident:	Name:
Insurance Company:	Address:
Insurance Address:	City, State, Zip:
City, State, Zip:	Contact:
Adjuster Name:	Phone:
Adjuster's Phone #:	File# / Claim#:
File# / Claim#:	

Patient's Agreement: I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician(s) of Chicago Anti-Aging Institute to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process insurance claims by provider or its agent(s). I fully understand and agree that my insurance policy is an agreement between myself and my insurance carrier and that any claims made by Chicago Anti-Aging Institute on my behalf are made only for my convenience and that I am responsible for all charges of Chicago Anti-Aging Institute whether or not they are covered by my insurance. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. This shall remain in effect until revoked by me in writing. I designate Chicago Anti-Aging Institute and agent(s), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from Chicago Anti-Aging Institute. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of all services incurred. I hereby order all parties to accept a copy of this release and assignment in lieu of the original.

Patient or Guardian's Signature _____ Date _____

Office use only	❑ Ins ❑ Medicare ❑ PI ❑ WC ❑ SP • ❑ FX ❑ 39 • ❑ NRB ❑ I/O ❑ HRDS	**CSI#**