Gibraltar Electro Medical Services

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)		BIRTH DATE (MMDDYYYY)	SEX ☐ M ☐ F
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP)			
SOCIAL SECURITY NUMBER	HOME PHONE	WORK PHONE	
EMPLOYER'S NAME			
EMPLOYER'S ADDRESS			

INSURANCE INFORMATION

TYPE OF CLAIM ☐ GROUP HEALTH ☐ PROPERTY CASUALTY ☐ AUTO ☐ OTHER:	IS INJURY WORK RELATED? ☐ YES ☐ NO
PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	INSURED'S NAME, IF OTHER THAN SELF
PRIMARY INSURANCE COMPANY'S NAME	ADJUSTER'S NAME
PRIMARY INSURANCE COMPANY ADDRESS	PHONE

GROUP / PLAN NUMBER	CLAIM / I.D. NUMBER	DATE OF INJURY
ATTORNEY NAME		PHONE

INFORMATION RELEASE / ASSIGNMENT OF BENEFITS / POWER OF ATTORNEY / LIEN

I authorize payment of medical benefits to GIBRALTAR ELECTRO MEDICAL SERVICES (GEMS) for performance of services rendered. This authorization for assignment of benefits also assigns GEMS the right to litigate or arbitrate any payment disputes with my applicable insurance carrier, and I immediately hereby irrevocably assign and transfer to GEMS any and all rights and benefits I may possess against or from my insurance company or health plan relating to the services rendered by GEMS. I authorize the release of any medical information required to process an insurance claim on my behalf. By this document, I specifically request GEMS to provide me with supplies for my neurostimulator for the period of time specified on the prescription issued by my doctor. I appoint GEMS, or any of its duly authorized agents, to endorse any and all checks, or drafts which are made payable to the undersigned alone, or to the undersigned and GEMS, which checks or drafts are to pay for services provided by GEMS at the request of or with the knowledge and/or approval of the undersigned. I hereby authorize and irrevocably direct my attorney, if any, to reimburse GEMS. in full, without compromise, for all services rendered, by disbursing funds, sufficient to pay GEMS, in full, received from any judgment or settlement directly to GEMS. I permit a copy of this authorization to be as valid as the original. All costs for services, rendered by GEMS, not paid for by my insurance company, or paid to GEMS as a result of a judgment or settlement, will be paid by me. In the event of a dispute between the parties to this agreement, the court venue shall be Los Angeles County, California; and, the prevailing party will be entitled to reasonable attorney fees, and all court costs, filing fees, and any other associated costs at trial and all levels of appeal. **My signature below denotes that I am aware I can choose to have my prescription filled at any location I choose, or by my treating physician and/or GEMS, and I have read, understand, and agree to the terms of this contractual agreement.**

_____ _____

PATIENT (OR RESPONSIBLE PARTY) SIGNATURE **DATE**

CLINIC AND PHYSICIAN INFORMATION

PHYSICIAN NAME	PHONE
CLINIC / PHYSICIAN ADDRESS	

Print Form Reset Form

P.O. Box 310342 / Fontana, CA 92331-0342 / TEL: 310-924-2899 / Support@Gems-Tens.com