GUARDIAN MEDICAL REVIEW
PHONE: (828) 243-7577 FAX: 1-800-850-2497 EMAIL: GETHELP@GUARDIANREVIEW.NET

CLIENT REGISTRATION

PLEASE PRINT WHEN COMPLETING THIS FORM

NAME: _____ DOB: _____ MALE ☐ FEMALE ☐

SS#: _____ (SS# IS REQUIRED WHEN DEALING WITH INSURANCE)

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

MAILING ADDRESS: _____

CITY, STATE: _____ ZIP CODE: _____

IF THE MEDICAL BILLS IN QUESTION ARE FOR SOMEONE OTHER THAN YOURSELF PLEASE COMPLETE THE FOLLOWING INFORMATION

RELATION TO YOU: _____ MALE ☐ FEMALE ☐

PATIENT NAME: _____ DOB: _____

SS#: _____ (SS# IS REQUIRED WHEN DEALING WITH INSURANCE)

MAILING ADDRESS: _____

CITY, STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE: _____ ID# _____

GROUP# _____ PHONE#: _____

SECONDARY INSURANCE: _____ ID# _____

GROUP# _____ PHONE#: _____

IF POSSIBLE, PLEASE PROVIDE A COPY OF THE FRONT & BACK OF INSURANCE CARDS

I AM SEEKING THE FOLLOWING SERVICES BY GUARDIAN MEDICAL REVIEW:

AUDIT OF MEDICAL BILLS ☐

HEALTH INSURANCE PLAN COUNSELING ☐

SIGN UP FOR AUTO REVIEW WITH GUARDIAN MEDICAL REVIEW AS MY "BILL TO" ADDRESS ☐

*CONSENT FORMS ARE CONTINUED ON PAGE 2 AND DO REQUIRE SIGNATURE.

GUARDIAN MEDICAL REVIEW
PHONE: (828) 243-7577 FAX: 1-800-850-2497 EMAIL: GETHELP@GUARDIANREVIEW.NET

CONSENT FORM

PATIENT NAME: _____ DOB: _____ LAST 4 SS#: _____

INITIAL: _____ MEDICAL RECORDS RELEASE: I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS, INCLUDING DETAILED FINANCIAL STATEMENTS, BY ANY HOLDER OF SUCH RECORDS TO: GUARDIAN MEDICAL REVIEW. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT REVOCATION MUST BE IN WRITING. I UNDERSTAND THAT REVOCATION WILL NOT APPLY TO INFORMATION ALREADY RELEASED BASED ON THIS AUTHORIZATION.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING TYPES OF DISCLOSURE:

1) COPIES OF RECORDS VIA FAX AND EMAIL 2) VERBAL INFORMATION/COMMUNICATION

I CAN BE REACHED AT THE FOLLOWING PHONE # TO VERIFY THIS AUTHORIZATION: _____

INITIAL: _____ RELEASE OF LIABILITY: I am 18 years or older and am voluntarily participating in this collaboration with GUARDIAN MEDICAL REVIEW regarding my medical billing. I understand that GUARDIAN MEDICAL REVIEW AND IT'S ASSOCIATES are not licensed insurance agents, certified healthcare providers, or a legal firm representing me as an attorney. I am retaining GUARDIAN MEDICAL REVIEW as a consultant regarding my healthcare benefits and costs and agree to hold GUARDIAN MEDICAL REVIEW harmless for any adverse outcomes by my participation in this endeavor.

INITIAL: _____ I HEREBY AUTHORIZE MY HEALTH INSURANCE PLAN (LISTED BELOW) TO COMMUNICATE WITH GUARDIAN MEDICAL REVIEW AND IT'S ASSOCIATES IN REGARDS TO MY CLAIMS, POLICY DETAILS, AND HEALTH RECORD INFORMATION AS I HAVE RETAINED GUARDIAN MEDICAL REVIEW AS A CONSULTANT FOR HEALTHCARE COVERAGE AND COSTS.

PRIMARY INSURANCE: _____ ID# _____

OTHER INSURANCE: _____ ID# _____

_____ DATE: _____

SIGNATURE OF PATIENT (OR PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE)

***PRIVACY POLICY, TERMS AND CONDITIONS AND MORE INFORMATION ARE AVAILABLE @ www.GuardianReview.net**

***IF YOU ARE AN APPOINTED GUARDIAN OR POA YOU WILL BE REQUIRED TO PROVIDE A COPY OF THE AUTHORIZING DOCUMENT.**

***MEDICARE WILL REQUIRE A SPECIFIC FORM BE COMPLETED TO COMMUNICATE WITH GUARDIAN MEDICAL REVIEW, WHICH WE CAN PROVIDE AND SUBMIT FOR YOU ONCE COMPLETED.**