



ACCOUNT ASSIGNMENT FORM

PLEASE  
PRINT ALL  
ENTRIES

RETURN COMPLETED FORM BY: EMAIL to **manager@crmcollect.com**  
-- OR -- by **Secure Upload** on our website -- OR -- by FAX to **(516) 430-5015**

PROVIDE COPIES OF ALL AVAILABLE RELEVANT AND SUPPORTING DOCUMENTATION:

Signed Contracts/Agreements, Credit Application(s), Patient Intake/Financial Responsibility Forms, Bills/Invoices, Purchase/Work Order(s), Payment Receipt, Returned/NSF Check(s), Drivers License, Insurance Card, Date of Birth\*, Social Security No.\*

\*D/O/B & SSN ARE CRITICAL FOR PROPER IDENTIFICATION AND CREDIT REPORTING OF YOUR DEBTOR

- Account 1 -

PLEASE PRINT	DEBTOR (LAST, FIRST, M.I. - INCL. CONTACT NAME IF COMMERCIAL)		CO-DEBTOR or GUARANTOR'S FULL NAME IF NOT DEBTOR	
	DEBTOR'S SSN (EIN IF COMMERCIAL)	D/O/B (MM/DD/YYYY)	GUARANTOR'S SSN (EIN IF COMMERCIAL)	D/O/B (MM/DD/YYYY)
	ALL KNOWN DEBTOR ADDRESSES		ALL KNOWN DEBTOR PHONE #'s	
	TOTAL AMOUNT OWING	YOUR IN-HOUSE ACCOUNT #	LAST DATE OF SERVICE	ORIGINAL DUE DATE FOR LAST SERVICE
	HAS THIS ACCOUNT PREVIOUSLY BEEN IN COLLECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS THIS ACCOUNT BEEN CHARGED OFF? <input type="checkbox"/> YES <input type="checkbox"/> NO	THIS ACCOUNT IS BEING ASSIGNED AS (MUST CHECK ONE) <input type="checkbox"/> CONTINGENCY FEE PRICING - MINIMUM CONTINGENCY ACCOUNT VALUE IS \$500.00 <input type="checkbox"/> FLAT FEE PRICING - MAXIMUM FLAT FEE ACCOUNT VALUE IS \$1,000.00	
	DID THE DEBTOR/PATIENT KEEP INSURANCE PAYMENTS? <input type="checkbox"/> NO <input type="checkbox"/> YES --->> AMOUNT REMITTED TO DEBTOR BY INSURANCE _____		INSURANCE COMPANY NAME: _____	
ADDITIONAL INFORMATION CONCERNING ACCOUNT:				

- Account 2 -

PLEASE PRINT	DEBTOR (LAST, FIRST, M.I. - INCL. CONTACT NAME IF COMMERCIAL)		CO-DEBTOR or GUARANTOR'S FULL NAME IF NOT DEBTOR	
	DEBTOR'S SSN (EIN IF COMMERCIAL)	D/O/B (MM/DD/YYYY)	GUARANTOR'S SSN (EIN IF COMMERCIAL)	D/O/B (MM/DD/YYYY)
	ALL KNOWN DEBTOR ADDRESSES		ALL KNOWN DEBTOR PHONE #'s	
	TOTAL AMOUNT OWING	YOUR IN-HOUSE ACCOUNT #	LAST DATE OF SERVICE	ORIGINAL DUE DATE FOR LAST SERVICE
	HAS THIS ACCOUNT PREVIOUSLY BEEN IN COLLECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS THIS ACCOUNT BEEN CHARGED OFF? <input type="checkbox"/> YES <input type="checkbox"/> NO	THIS ACCOUNT IS BEING ASSIGNED AS (MUST CHECK ONE) <input type="checkbox"/> CONTINGENCY FEE PRICING - MINIMUM CONTINGENCY ACCOUNT VALUE IS \$500.00 <input type="checkbox"/> FLAT FEE PRICING - MAXIMUM FLAT FEE ACCOUNT VALUE IS \$1,000.00	
	DID THE DEBTOR/PATIENT KEEP INSURANCE PAYMENTS? <input type="checkbox"/> NO <input type="checkbox"/> YES --->> AMOUNT REMITTED TO DEBTOR BY INSURANCE _____		INSURANCE COMPANY NAME: _____	
ADDITIONAL INFORMATION CONCERNING ACCOUNT:				

I/We assign to Capital Resource Management, Inc. (CRM) the above listed account(s) for debt collection in accordance with the Terms and Conditions of Collection Services. I/We will immediately report to CRM any contact or payment made towards these accounts.

Client \_\_\_\_\_ (COMPANY OR REPRESENTATIVE SUBMITTING THE CLAIM)      Creditor \_\_\_\_\_ (COMPANY OR INDIVIDUAL OWED THE MONEY IF DIFFERENT THAN CLIENT)  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Signature \_\_\_\_\_ Name Printed \_\_\_\_\_ Date \_\_\_\_\_

CLEAR ALL ENTRIES