Capital Resource Management, Inc.

2059 Merrick Road, Ste. 116
Merrick, NY 11566
www.crmcollect.com

Tel 516-442-4045
Fax 516-430-5015
Toll Free 1-844-277-3277

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 ($500.00 minimum)	YOUR IN-HOUSE ACCOUNT #	LAST DATE OF SERVICE	DATE ACCOUNT BECAME DELINQUENT
HAS THIS ACCOUNT PREVIOUSLY BEEN IN COLLECTIONS? ☐ YES ☐ NO	HAS THIS ACCOUNT BEEN CHARGED OFF? ☐ YES ☐ NO	DID THE DEBTOR/PATIENT KEEP INSURANCE PAYMENTS? ☐ NO ☐ 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 ($500.00 minimum)	YOUR IN-HOUSE ACCOUNT #	LAST DATE OF SERVICE	DATE ACCOUNT BECAME DELINQUENT
HAS THIS ACCOUNT PREVIOUSLY BEEN IN COLLECTIONS? ☐ YES ☐ NO	HAS THIS ACCOUNT BEEN CHARGED OFF? ☐ YES ☐ NO	DID THE DEBTOR/PATIENT KEEP INSURANCE PAYMENTS? ☐ NO ☐ 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 _____ **Creditor** _____
(COMPANY OR REPRESENTATIVE SUBMITTING THE CLAIM) *(COMPANY OR INDIVIDUAL OWED THE MONEY IF DIFFERENT THAN CLIENT)*

Address _____ **Phone**_____

Signature _____ **Name Printed** _____ **Date** _____

CLEAR ALL ENTRIES