



**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 Receipts, 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

WE MUST HAVE A COPY OF THE LAST INVOICE/STATEMENT SENT TO YOUR DEBTOR TO COMMENCE COLLECTIONS.

**PLEASE PRINT**

DEBTOR'S FULL NAME (LAST, FIRST, M.I. (INCL. CONTACT NAME IF COMMERCIAL))		DEBTOR'S SSN (EIN IF COMMERCIAL)		D/O/B (MM/DD/YYYY)	
ALL KNOWN DEBTOR ADDRESSES				ALL KNOWN DEBTOR PHONE #'s	
CO-DEBTOR'S FULL NAME (LAST, FIRST, M.I.)		CO-DEBTOR'S SSN (EIN IF COMMERCIAL)		D/O/B (MM/DD/YYYY)	
ALL KNOWN CO-DEBTOR ADDRESSES				ALL KNOWN CO-DEBTOR PHONE #'s	
FULL NAME OF FINANCIALLY RESPONSIBLE PARTY - IF NOT DEBTOR ABOVE.		GUARANTOR'S SSN (EIN IF COMMERCIAL)		D/O/B (MM/DD/YYYY)	
ALL KNOWN GUARANTOR'S ADDRESSES				ALL KNOWN GUARANTOR PHONE #'s	
MINOR CHILD'S NAME AND DOB IF DEBT IS FOR SERVICES TO A MINOR					
TOTAL AMOUNT DUE (\$500.00 min)		YOUR IN-HOUSE ACCOUNT #		LAST DATE OF SERVICE	
LAST PAYMENT RECEIVED DATE		DATE ACCOUNT BECAME DELINQUENT		LAST INVOICE SENT DATE	
		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	
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 named Debtor's account 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