



ASSOCIATES IN INTERNAL MEDICINE P.A.

I, \_\_\_\_\_, understand it is my responsibility to provide Associates in Internal Medicine, P.A. of present and/or changes of insurance coverage, preferred providers, referrals, laboratory company, and/or imaging company, as well as address and telephone.

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_