SECONDARY INSURANCE

Please provide copy of card to receptionist to attach to this form.

Insurance Company:______________________ Address:______________________ (____)__________
STREET or P.O. BOX PHONE #

Co-Pay Amount: (If applicable)______________________ ______________ ____ ______
CITY ST ZIP

PCP:______________________________

Policy Holder:____________ ____________ ____ ____ __/__/__ ________
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other______________________
(SPECIFY)

Employer's Name:______________________ ______________ ______________________
INSURED ID GROUP NAME AND/OR NUMBER

Address:______________________ ______________ ____ ______
STREET CITY ST ZIP

WORKMAN'S COMPENSATION

Workman's Compensation Insurance Name:______________________ Adj__________

Address______________ City__________ State_____ Zip_______ Phone__________

Claim #______________________ DOI______________________

What Employer____

ACCIDENT INFORMATION

Was this the result of an accident? ____ Yes ____ No Where did it occur? ____ At Work ____ Auto Accident ____ Other

Date of the Accident______________ Have you reported the injury to your employer? Yes No When__________

Describe accident briefly:____

Do you have an attorney representing you? Yes No Who is the attorney?______________________

·REFERRAL INFORMATION

Who referred you?______________ Address______________ Phone #__________

Family Physician______________ Address______________ Phone #__________

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ:

Texas Health Care, P.L.L.C. (THC), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that THC has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

______________________ ____________ ______________________ ____________
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE