# Patient Demographics/Insurance

**Patient:** **Date:**________________

Name (first) _________________________(last) ____________________(middle) ________________

Mailing Address _________________________________City______________State_____ Zip_______

Date of Birth__________________ Social Security #______________________ Marital Status_______

Home Phone ( ) __________________Cell ( ) _________________Work ( )_______________

Preferred method of contact: phone_____ Cell______ email______

Email address___________________________________________________________________________

Occupation _____________________________________________________Sex: Male___ Female___

Local Contact ____________________________Phone( )______________Cell( )_______________

**Responsible Party:**

Name (first)_____________________( Last)___________________Relationship to Patient:__________

Address_______________________________________City_____________State_______Zip__________

Phone ( )_______________Cell( )______________ ___ Social Security #__________________

Employer_______________________________ Occupation __________________________________

Employer Address______________________________ City______ __State ________Zip___________

Phone ( )__________________________ Date of Birth_________________________

Local Contact ____________________________Phone( )_____________Cell( )_______________

**Primary Insurance:**

Company Name___________________________ Effective date__________ Specialist copay_______

**Policy Holder:** Name (first)____________________________( Last)_____________________________

Date of Birth_____________________________Relationship to patient:________________________

Address_______________________________________City_____________State_______Zip__________

Phone ( )_______________Cell( )_________________ Social Security #__________________

Employer___________________________Phone( )__________ Occupation ___________________

Employer Address______________________________ City______ ___State ________Zip___________

**Secondary Insurance:**

Company Name______________________________ Effective date__________ Specialist copay_______

**Policy Holder:** Name (first)_____________________________( Last)____________________ __________

Date of Birth____________________ Relationship to patient:____________________ ____

Address_______________________________________City_______________State_______Zip__________

Phone ( )_______________ Cell( )____________________ Social Security #__________________

Employer_____________________________ Phone( )_________ _Occupation __________________

Employer Address______________________________ City__________ State ________Zip___________

PATIENT NAME (PRINT): ______________________________________ Date of Birth:_______________

## AUTHORIZATION

By signing this form, I consent to examination and treatment by a physician of TEXAS HILL COUNTRY ORTHOPEDICS & SPORTS MEDICINE P.A. I acknowledge the medical and demographic information I have given is true and accurate. I authorize you to obtain information pertaining to my treatment from other physicians including without limitation to any lab or diagnostic testing needed for treatment purposes.

**X Signature:** ________________________________________ **Date:** __________________

## FINANCIAL PAYMENT POLICY

Responsible Party (at least 18 years of age) must sign:

The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Insurance is considered a method of reimbursing the doctor for services rendered, and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other insurance companies pay a percentage of the charge. It is my responsibility to pay the deductible amount, co-payments, co-insurance, out of network % and/or any other balance not paid by my insurance company, as applicable. **Payment is expected at the time services are rendered.**

I hereby understand the financial policy stated above.

**X Signature:** ________________________________________ **Date:** __________________

**Print Name:** ___________________________________ **Relationship to Patient**: __________________

## RELEASE OF MEDICAL INFORMATION

I authorize the following to have access to my medical information:

Name:_________________________________ Relationship: ______________ Phone:_____________

Name:_________________________________ Relationship: ______________ Phone:_____________

**X Signature:** ________________________________________ **Date:** __________________

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with an opportunity to review (or a copy if requested) of the Notice of Privacy Practices of TEXAS HILL COUNTRY ORTHOPEDICS & SPORTS MEDICINE P. A.

**X Signature:** ________________________________________ **Date:** __________________

* * * * * * * **Employee Initials:** _____________ **Date:** _________________ * * * * *