Dallas Center for Pelvic Medicine
10501 North Central Expressway
Suite 200
Dallas, Texas 75231

PATIENT INFORMATION

Acct #:	**Date of Birth**:
Name:	**Social Security #**:
Address One:	**Sex**:
Address Two:	**Who referred you?**
City:	**Primary Care Dr**:
State: **Zip**:	**Marital Status:**
Home Phone#:	**Employment Status**: *Circle One*
Work Phone#:	*FT / PT / Self / Not Employed / Retired / Military*
Mobile Phone#:	**Employer:**
Email Address:	**Student Status**: *FT / PT / Not a Student*

EMERGENCY INFORMATION

Name:
Relationship to Patient:
Telephone #:

INSURANCE POLICY INFORMATION

Primary Insurance:	**Secondary Insurance**:
Subscriber:	**Subscriber**:
ID#:	**Certificate#**:
Subscriber DOB:	**Subscriber DOB**:
Group Number:	**Group Number**:
Employer Name:	**Group Name**:

If you would like for us to be able to discuss your medical condition and treatment with a spouse, parent, family member, friend or caregiver, we need your written authorization to do so. Please list the names and relationship of anyone you would like to authorize to have access to your health information.

Name	Relationship
1.	
2.	
3.	
4.	

Patient
Signature:____Date:______________________

***Patient Name:*_______________________________**
***Date of Birth:*_______________________________**

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

Please read and initial each paragraph

_______Dallas Center for Pelvic Medicine and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_______I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Dallas Center for Pelvic Medicine for any services furnished to my by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_______I appoint Dallas Center for Pelvic Medicine to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_______Unless I request to the contrary in writing, I will accept appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of this practice

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through ____________________________________

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office
- The remainder of your bill will be sent to your health plan for direct payment to our office
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
  1) This is a pre-existing illness that is not covered by your plan
  2) You have not met your full calendar year deductible
  3) The type of medical service required is not covered by your plan
  4) The health plan was not in effect at the time of service
  5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Dallas Center for Pelvic Medicine

I have completed this form with accurate information and have read and understand my obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

____ ______________________

Signature of Patient Date