Please fill out completely, or it may delay your visit* ***ACCT #:***

Patient Name:			
Address:	**City:**	**State:**	**Zip:**
Home#:	**Cell#:**		
Email address:			
SS#:	**DOB:**	**Age:**	
Sex:	**Race:** ☐Caucasian ☐Hispanic ☐Asian ☐African American ☐ Indian ☐Other		
Employer:	**Work#:**	**Language:_____**	
Ethnicity: ☐Hispanic ☐Non-Hispanic	Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed		
Pharmacy (MANDATORY) Address:		**Phone #:** **Fax #:**	

MINOR CHILDREN (UNDER 18)

Responsible Party: Name: _____Relation:_____

Address:_____

DOB:_____ Social Security #:_____

☐***WORKERS COMP. INSURANCE*** ☐***NO INSURANCE***

Primary Insurance:		☐ **Same as Patient**
Policy Holder Name:		**Relationship: _____**
DOB:_____	**SS #:_____**	
Insurance ID:	**Group#:**	
Secondary Insurance:		☐ **Same as Patient**
Policy Holder Name:		**Relationship:_____**
DOB:_____	**SS#:_____**	
Insurance ID:	**Group #:**	
Primary Doc: **Phone#:** **Fax #:**	**Referring Doc:** **Phone #:** **Fax #:**	
How did you hear of us? ☐**Other** ☐**ER_____** ☐**Yellow Pages** ☐**Friend** ☐**Website**		

Release of medical information authorization: I hereby consent for WLO to discuss my treatment, billing, and appointment scheduling with: Ex: mother-father-friend-spouse

Name:_____Relation:_____Ph:_____

AUTHORIZATIONS AND ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician to release information in connection with my treatment to my insurance company, my employer, their representative, or referring physician, at such time as information is requested. I authorize assignment of benefits to my physician.

DURABLE MEDICAL EQUIPMENT

I understand and assume financial responsibility for payment in full of the DME used involved in my medical treatment or surgery, should my insurance deny any charges. DME can include cryo units, braces, immobilizers, crutches, pain pumps and etc. I understand that there are no guarantees for payment until the claim is reviewed by my insurance carrier.

OFFICE POLICY ON STANDARD INSURANCE AND MANAGED CARE INSURERS

I hereby acknowledge having received and reviewed the policies concerning managed care programs, self-pay, Medicare, auto-accidents, and workers compensation.

POLICIES AND FEES FOR MEDICAL RECORDS, XRAY DUPLICATION, DISABILITY FORMS, AND CO-PAYS

I hereby acknowledge having received and reviewed the policies. The above office policies are set in accordance with Texas Medical Board regulations and offices in this area.

OFFICE APPOINTMENT CANCELLATION POLICY

We require a 24 hour cancellation notice. If you fail to do so there will be a $25 charge to your account.

PROTECTED HEALTH INFORMATION:

I hereby acknowledge having reviewed Westlake Spine and Sports Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document upon request.

DISCLOSURE OF PHYSICIAN OWNERSHIP

I hereby acknowledge having reviewed the Disclosure of Physician Ownership.

I understand that by signing here, I authorize WLO and its representatives to contact me by E-mail, telephone, mail or fax to provide billing, scheduling, treatment/ health-related benefits and services that are of interest to me.

I understand by signing here, I acknowledge to have read the above policies and procedures. There are several binders in our lobby with our policies and procedures. If you wish to have a copy, please notify our staff.

Patient Signature-Guardian:_____Date: _____

CONSENT FOR TREATMENT:

I do hereby consent to necessary examinations, procedures, and/or treatment by the physician, his/her assistants, and designees as is necessary in his/her judgment.

Patient Signature-Guardian:_____ Date:_____