**HOUSTON SPINE & SPORTS MEDICINE**
**MOTION PHYSICAL THERAPY**

25216 GROGANS PARK DR. THE WOODLANDS, TX 77380
281-357-5454 FAX: 281-357-5499

**SHAUN D. LEHMANN, M.D.◆ CURTIS D. FANDRICH, D.O**

**Date_____ Please provide us with your Texas Driver's License and Insurance Card(s)**

## *Patient Information*

**Name_____ Date of Birth:_____ Age_____ Sex: M F**

**Address_____ City_____ State_____ Zip_____-____**

**Home Phone #_____ Mobile Phone #_____ S.S.#_____**

**Employer_____ Work Phone #_____**

**Emergency Contact Person _____ Phone # _____**

**Primary Care Physician:_____ Pharmacy:_____ Phone#_____**

**How did you find out about us? _____ Email:_____**

## *Insured's Information*

**Policy Holder's Name_____ Relation_____ Date of Birth _____Sex: M F**

**Address** (if different from above**)_____ City_____ State _____ Zip_____**

**Home Phone #_____ S.S. #_____ TDL#_____**

**Employer_____ Work Phone # _____**

## *Insurance Information*

***Primary Insurance*_____ Policy #_____ Group #_____**

**Name of Insured_____ S.S.#_____ DOB_____**

**Insurance Address _____ Insurance Phone #_____**

***Secondary Insurance*_____ Policy # _____ Group # _____**

**Name of Insured_____ S.S. #_____ DOB_____**

**Insurance Address_____ Insurance Phone #_____**

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Center for Spine, Sports & Physical Medicine, P.A. the amount due on my claim, for services to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expenses, I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. A photocopy of this agreement shall be considered as effective and valid as the original.

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Center for Spine, Sports & Physical Medicine, P.A. to release any medical information acquired in the course of my examination or treatment as may be necessary for the completion of my insurance claims to any insurance carrier, hospital or health plan.

## DISCLOSURE

If I am referred to Motion Physical Therapy for rehabilitation services, I understand that it is a subsidiary of Center for Spine, Sports, & Physical Medicine, P.A. If I am referred to Alliance for imaging services, I understand that it is an affiliation of Center for Spine, Sports & Medicine, P.A.

## CANCELLATION POLICY

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $55.00.

## NOTICE CONCERNING COMPLAINTS

Assistance in filing complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, may be reported for investigation by calling the following telephone number, 1-800-201-9353.

Patient (Guardian) Signature Date

Guarantor Signature Date