
HOUSTON SPINE & SPORTS MEDICINE

SHAUN D. LEHMANN, M.D. ♦ CURTIS D. FANDRICH, D.O
25216 Grogans Park Dr. Ste A The Woodlands, TX 77380
281-357-5454 ♦ 281-357-5499

Date _____

Patient Information Please provide us with your Texas Driver's License and Insurance Card

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

<i>Primary Insurance</i> _____	Policy # _____	Group # _____
Name of Insured _____	S.S.# _____	DOB _____
Insurance Address _____	Insurance Phone # _____	
<i>Secondary Insurance</i> _____	Policy # _____	Group # _____
Name of Insured _____	S.S. # _____	DOB _____
Insurance Address _____	Insurance Phone # _____	

PLEASE TURN PAGE OVER TO CONTINUE

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.

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 \$75.00.

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