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SHAUN D. LEHMANN, M.D. ♦ CURTIS D. FANDRICH, D.O
DAN E. WILSON, D.O ♦ ADAM WEGLEIN, 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.

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 \$45.00.

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