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.

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