LifeCare Primary Medical Associates,PLLC.

633 E Fernhurst Dr. Suit 202. Katy, TX-77450, Tel: 281-712-7757, Fax: 281-712-7758

Patient Registration Form

Patient's Name:____

Age:____________________ Sex:__________________ Birthdate:________________

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Social Security No.______________________ Home Phone No.______________________

Cell Phone No.______________________ Email:________________________________

Home Address:____

City:__________________________ State:__________________ Zip:________________

Patient Employed By:______________________________ Occupation:________________

Business Address:_________________________ Business Phone:____________________

City:__________________________ State:__________________ Zip:________________

Spouse Name:___________________________ Social Security No.____________________

Referred By ☐ Physician ☐ Hospital ☐ Other (Please Specify)

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If Patient is Minor, Name of Responsible Parent______________________________________

Pharmacy Name & Phone No.____

CONTACT CONCENT

I____________________________(Patient Name) give LifeCare Primary Medical Associates, PLLC, staff authorization to release my personal and confidential information to:

Name:______________________ Relation:_________________ Phone No.________________

Name:______________________ Relation:_________________ Phone No.________________

Name:______________________ Relation:_________________ Phone No.________________

INSURANCE INFORMATION

Name, Address & Phone No. of ***Primary Insurance:***

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Name, Address & Phone No. of ***Primary Insurance:***

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Name, Address & Phone No. of ***Primary Insurance:***

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ATHORIZATION TO PAY PROVIDER & MEDICAL RELEASE

I hereby authorize *LifeCare Primary Medical Associates, PLLC* and affiliated or other providers to release any information acquired in the courses of my treatment to my insurance company, employer or third-party payer as enquired for claims filed, quality assurance, health plan administration, complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including Human Immune-Deficiency Virus (HIV) and Acquired Immune Deficiency (AIDS).
I authorize direct payment to be made to the office of '*LifeCare Primary Medical Associates, PLLC* or other providers for any and all medical or surgical services rendered. I certify that the information above is true and correct to the best of my knowledge.

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SIGNATURE AUTHORIZING the release of personal & confidential information
to the ***CONTACTS*** listed above, to my ***INSURANCE*** Company (for billing purposes ONLY),
& to ***AUTHORIZE PAYMENT TO THE PROVIDER***