ERIC I. RAY, M.D.
731 E. SOUTHLAKE BLVD., SUITE 110, SOUTHLAKE, TEXAS 76092
817-898-7277 FAX 817-527-5119

PATIENT INFORMATION

PATIENT REGISTRATION INFORMATION

Name: _____
First MI Last

Home Phone: _____ Work Phone: _____

Address: _____
Street Apt. City State Zip

DOB: _____ Age: _____ Sex: _____ Social Sec. #: _____

Driver's License #: _____ Reason for Visit: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ Primary Physician: _____

Are you employed? __ Yes __ No __Full-Time __Part-Time __Self-Employed __Retired
Are you a student? __ Yes __No __Full-Time __Part-Time __
Marital Status: __ Single __Married __Divorced __Widowed
Is the patient: __a minor child* __ an adult dependent*
***If you checked either, please see the receptionist for additional information.**

PRIMARY INSURANCE INFORMATION

Please present your card at each visit. Deductible amount:_____ Co-pay Amt:_____ PCP:_____

Insurance Company Name Claims Mailing Address City State Zip

Telephone Contact Person Group # Policy #

Primary Insured Insured's DOB Insured's SSN Relationship to Pt

Employer: _____

SECONDARY INSURANCE INFORMATION

Please present your card at each visit. Deductible amount:_____ Co-pay Amt:_____ PCP:_____

Insurance Company Name Claims Mailing Address City State Zip

Telephone Contact Person Group # Policy #

Primary Insured Insured's DOB Insured's SSN Relationship to Pt

Employer: _____

ACCIDENT INFORMATION

Is this illness/injury the result of an accident? __Yes __No
Where did the accident occur? __ Work __ Auto __ Other Date of Accident: _____
Have you reported the illness/injury to your employer? ____Yes ___No

Print Name: _____ Patient Initials: _____

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appt of Authorized Representative

****Please read and initial each paragraph****

_____ SOUTHLAKE PAIN CENTERand associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to SOUTHLAKE PAIN CENTERfor any services furnished to me by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____ I appoint SOUTHLAKE PAIN CENTERto act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ Unless I request to the contrary, in writing, I will receive appointment reminders on my home telephone answering system and/or other information regarding my treatment or invoices by mail to my home address.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through _____.

- **If you have out-of-network benefits, we will happily file claims on your behalf.**
- **You must pay any co-payment and applicable deductible amounts at the time of services unless other arrangements have been made with our office.**
- **The remainder of your bill will be sent to your health plan for direct payment to our office.**
- **If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.**
- **If, by mistake, your health plan remits payment to you, you will send it to us along with all paperwork which accompanied it.**
- **Your health plan may refuse payment of a claim for some of the following reasons:**
  1) **If it is a pre-existing illness that is not covered by your plan.**
  2) **You have not met your deductible for the full calendar year.**
  3) **The type of medical service required is not covered by your plan.**
  4) **The health plan was not in effect at the time of the service.**
  5) **You have other insurance which must be filed first.**

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Eric I. Ray, M.D. PLLC

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Patient Name: _____

Patient Signature: _____ Date: _____

EMAIL ADDRESS: _____