TEXAS OCCUPATIONAL MEDICINE INSTITUTE

Today's Date ___________________ PLEASE PRINT

PATIENT INFORMATION

LAST NAME ________________________ DATE OF BIRTH _____/_____/_____.

FIRST NAME ________________________ SEX M F

ADDRESS ________________________ SOCIAL SECURITY _____-_____-_____.

________________________ EMPLOYER NAME ________________________

CITY ________________________ EMP STATUS: FULL PART RETIRED SELF

STATE ______________ ZIP ______________ STUDENT STATUS FULL PART

HM PHONE ______________ CELL ______________ MARITAL STATUS S M D W

WK PHONE ______________ EXT ________ SPOUSE NAME ________________________

EMAIL ________________________

EMERGENCY CONTACT ________________________ RELATIONSHIP ________________________

HM PHONE ______________WK PHONE ______________ EXISTING PT Y N

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CO NAME ________________________ INSURANCE PHONE ________________________

POLICYHOLDER/SUBSCRIBER OF INSURANCE(RELATION TO PT): SELF SPOUSE PARENT/GUARDIAN OTHER

MEMBER I.D. # ________________________ GROUP # ________________________

IF SPOUSE OR PARENT/LEGAL GUARDIAN PLEASE COMPLETE:

NAME POLICY/SUBSCRIBER: ____

(LAST) (FIRST) (MI)

SS#_____/_____/_____ D.O.B _____-_____-_____ EMPLOYER ________________________

SECONDARY INSURANCE

INSURANCE CO NAME ________________________ INSURANCE PHONE ________________________

POLICYHOLDER/SUBSCRIBER OF INSURANCE(RELATION TO PT): SELF SPOUSE PARENT/GUARDIAN OTHER

MEMBER I.D. # ________________________ GROUP # ________________________

IF SPOUSE OR PARENT/LEGAL GUARDIAN PLEASE COMPLETE:

NAME POLICY/SUBSCRIBER: ____

(LAST) (FIRST) (MI)

SS#_____/_____/_____ D.O.B _____-_____-_____ EMPLOYER ________________________

I have read, understand, and agree to abide by the policies stated on page 2 of this form.

________________________ ________________________ ________________________

Patient Name (Please print) **Patient or Responsible Part Signature** **Date**

AUTHORIZATION AND CONSENT

I hereby authorize the physicians and staff of Texas Occupational Medicine Institute to release any information acquired in the course of my treatment to my insurance company or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health.

I authorize direct payment to be made to the physicians of Texas Occupational Medicine Institute for any and all medical or surgical services rendered. I understand that if any service or charges are not covered, or if Texas Occupational Medicine Institute is unable to verify eligibility that I am responsible for all charges incurred for services rendered.

________________________ ________________________ ________________________

Patient Name (Please print) **Patient or Responsible Part Signature** **Date**

Office, Financial and HIPAA Policies Acknowledgement

Welcome to Texas Occupational Medicine Institute. TOMI's main goal is to provide the best quality of care for their patients. The doctors or staff of TOMI will not perform any services that they do not feel are reasonable or necessary for your wellbeing. We will strive to make your visits to our office as comfortable as possible. Please read and sign these policies before your treatment so that you will have a better understanding of our office policies.

Payment in Full is due at the time services are rendered. We accept cash and checks. All non-cash transactions and/or services that are to be filed to insurance require a legal form of picture identification (driver's license, state identification card, passport) and your social security number. Texas Occupational Medicine Institute will file your claim to those insurance companies with whom we have current contracts. We do not accept Discount Plans or Medicaid and all of our charges are reasonable and customary for this geographical area.

There is a **$30.00 charge** on all **Returned Checks** and we do not accept post-dated checks.

Insurance Contracts obligate your physician to collect co-pay, deductible, or co-insurance amounts from you. As a courtesy, this office attempts to verify your insurance benefits prior to any services you may receive but the information we receive is not a guarantee of payment and you are ultimately responsible for knowing your plan benefits and requirements and are therefore responsible for any and all co-pays, deductibles, co-insurance and non-covered services as identified on the explanation of benefits we receive from your insurance plan.

It is your responsibility to notify Texas Occupational Medicine Institute of any change in insurance coverage. Failure to provide this office with current insurance information at the time of service may result in you being held responsible for the full amount of the charges due to the claims filing deadlines required by your insurance which are typically 90-days or less.

Many insurance plans require prior-authorizations for certain tests, referrals, ER visits, and/or treatment. These must be obtained prior to treatment. Without the proper authorization, your insurance may refuse to pay, and you will be responsible for all charges. It is the patient's responsibility to provide TOMI with any required referrals.

For your convenience and safety, **prescriptions** are issued during office hours only. If you take medication for a chronic condition, you are required to see the physician on a regular basis. It is your responsibility to plan ahead, so that you do not run out of your medications.

You may be assessed a $25.00 **no-show fee** for any appointment not cancelled at least 24 hours before appointment.