

Jose Rivas, M.D. _____
Tony Bui, M.D. _____

Visiting Physician's Network
5440 Harvest Hill Rd. Suite 182
Dallas, TX 75230
Office 972-484-0040 Fax 972-484-0070

David Green, M.D. _____
Marvetta Scott, M.D. _____
Pedro Zevallos M.D. _____

COMMUNITY _____

PHONE _____

PATIENT INFORMATION

NAME AS IT APPEARS ON INSURANCE CARD:		SEX : ____M ____F
Date of Birth:	SS#	Phone: HOME _____ CELL _____
Race: ____ White ____ Asian ____ Black or African American ____ American Indian or Alaska Native ____ Native Hawaiian or other Pacific Islander	ETHNICITY: ____ Non Hispanic or Latino ____ Hispanic or Latino	PRIMARY LANGUAGE: ____ ENGLISH ____ SPANISH ____ OTHER _____
ADDRESS WHERE PATIENT WILL BE SEEN		
CITY:	STATE:	ZIP CODE:

BILLING INFORMATION

PRIMARY INSURANCE NAME :	POLICY NUMBER:	
ADDRESS IF INSURANCE IS OTHER THAN MEDICARE OR MEDICAID	PHONE	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
ADDRESS IF INSURANCE IS OTHER THAN MEDICARE OR MEDICAID	PHONE	
ADDRESS TO SEND STATEMENT IF OTHER THAN PATIENT' S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT:	
IS THIS PERSON POWER OF ATTORNEY ____ Yes ____ No	PHONE NUMBERS: Home: Cell: Other:	
CURRENT PRIMARY CARE PHYSICIAN	HOSPITAL PREFERENCE	PHARMACY PREFERENCE/LOCATION Pharmacy name: Ph number: Pharmacy address:

I understand that the physicians of Visiting Physician's Network accept most insurance plans and that I will be financially responsible for payment of services if payment is denied by my insurance company. I also will be responsible for payment if I choose to cancel Medicare part B coverage. It is my responsibility to notify Visiting Physician's Network of any change in insurance coverage. I hereby assign the attending physician and Visiting Physicians Network my benefits that are payable for medical services rendered by providers of Visiting Physicians Network. I authorize my physician and Visiting Physicians Network to furnish my insurance company any medical information necessary for payment of any claim. I also understand that Visiting Physicians Network is a Medicare participating provider and that Visiting Physicians Network accepts Medicare's approved amount for services. I also understand that Medicare pays 80% of the approved amount and either I or my secondary insurance will be responsible for the remaining 20%. I also understand that there is an annual Medicare deductible that will my responsibility if my secondary insurance does not pay.

SIGNATURE _____

DATE _____

Visiting Physician's Network
5440 Harvest Hill RD Dallas, TX # 182, 74230
T: (972) 484-0040
F: (972) 484-0070

Authorization for Release of Medical Records

I _____ hereby authorize _____ to

Release the following medical records to Dr. _____ and his associates.

- | | |
|---|---|
| <input type="checkbox"/> Emergency Room Reports | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> EKG's | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Doctor's Orders | <input type="checkbox"/> Nurses Notes |
| <input type="checkbox"/> Other _____ | |

From the medical records of: _____
(Patient's name)

Patient's Date of Birth _____

To help us expedite the attainment of your medical records, please provide us with the name, Address and phone number of your primary care physician.

Previous Doctor's Name: _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Reason for release of records:

Change of Primary Care Physician Other _____

Signature _____ Date _____

Witness _____ Date _____

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CONSENT TO TREAT FORM

I voluntarily give my permission to Visiting Physician's Network to provide Medical services as deemed necessary to me. I understand by signing this form, I am authorizing Visiting Physician's Network and any of their associates to treat me as long as I seek medical services, or until I withdraw my consent in writing.
Visiting Physician's Network

Signature _____ Date _____

Printed Name of Patient _____

Substituted Consent

Because the patient is unconscious or has been determined by his/ her attending Physician to not be competent to give consent (reason _____), I, _____ hereby give my consent on the patient's behalf.

Signature _____ Date _____

Witness Signature _____ Date _____