Jose Rivas, M.D____ **Visiting Physician's Network** **David Green, M.D.____**
Tony Bui, M.D. ____ **5440 Harvest Hill Rd. Suite 182** **Marvetta Scott, M.D.___**
Dallas, TX 75230 **Pedro Zevallos M.D. ____**
Office 972-484-0040 Fax 972-484-0070

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.

- __ **Emergency Room Reports**
- __ **Face Sheet**
- __ **History & Physical**
- __ **EKG's**
- __ **Doctor's Orders**
- __ **X-Ray Reports**
- __ **Discharge Summary**
- __ **Consultation Reports**
- __ **Progress Notes**
- __ **Nurses Notes**
- __ **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_____

5440 Harvest Hill Rd Dallas, TX # 182
T: (972) 484-0040
F: (972) 484-0070

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_____