

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

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. _____

Facility Name _____

Facility Ph: _____

Patient Information

Name as it appears on card: _____

Sex _____

Date of Birth: _____

SS# _____

Phone: _____

Cell Num: _____

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

Street : _____ Rm/Apt _____ CITY: _____ STATE: TX ZIP CODE: _____

EMAIL ADDRESS FOR PATIENT PORTAL NOTIFICATION : _____

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 of Secondary Insurance

PHONE

EMERGENCY CONTACT or POA Send Statement/Bill to this address? YES ___ NO ___

NAME: _____ RELATIONSHIP TO PATIENT: _____

Mailing address: Street _____ City _____ State _____ Zip _____

Address to send statement if not patient or Emergency contact Name _____

Street address _____ City _____ State _____ Zip _____

IS THIS PERSON POWER OF ATTORNEY
____ Yes ____ No

PHONE NUMBERS: Home:
Cell: _____

Other: _____

CURRENT PRIMARY CARE PHYSICIAN

HOSPITAL PREFERENCE

PHARMACY PREFERENCE/LOCATION

Name: _____

Pharmacy name:

Address: _____

Pharmacy address:

City _____ State _____

Zip _____ Ph: _____

I understand the physicians of Visiting Physician's Network do not accept Medicare HMO plans and that I will be financially responsible for payment of services if payment is denied by Medicare due to any participation in an HMO program. 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 any money payable to me under my insurance coverage and / or other arrangements with third parties for payment of such services. I authorize the attending physician to furnish my insurance company any medical information necessary for payment of any claim. I also agree to be responsible for any testing or treatment that may not be requested considered by my insurance company to be medically necessary. Signature below is also patient or POA's consent to treat patient. Consent may be withdrawn at any time by verbal or written notification Visiting Physicians Network.

SIGNATURE Pt/Responsible party

DATE

Visiting Physician's Network
5440 Harvest Hill RD Dallas, TX # 182, 75230
T: (972) 484-0040
F: (972) 484-0070

Authorization for Release of Medical Records (This Section For Office Completion)

I _____ hereby authorize _____ to

Release the following medical records to Visiting Physicians Network, Inc. Dr
This consent is for any medical records that my previous physician has and for any medical records from hospitals or medical providers while I am a patient of a physician of Visiting Physicians Network.

-
- | | |
|---|---|
| <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: _____ Date of birth _____
(patients name)

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: Changing to a new primary care physician and ongoing continuity of care

Signature _____ Date _____

Witness _____ Date _____