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.____
Pedro Zevallos, M.D. _____

FacilityName ____ 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 Name:________________________________ Address:______________________________ City_____________________ State_______ Zip___________ Ph:____________________	HOSPITAL PREFERENCE	PHARMACY PREFERENCE/LOCATION Pharmacy name: Pharmacy address:

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.

__ Emergency Room Reports

__ Face Sheet

__ History & Physical

__ EKG's

__ Doctor's Orders

__ Other ______________________________________

__ X-Ray Reports

__ Discharge Summary

__ Consultation Reports

__ Progress Notes

__ Nurses Notes

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____________________