Texas Healthcare, P.L.L.C.
P.O. Box 961205
Fort Worth, Texas 76161-1205

Alan Johns, M.D.

Date

Select One

☐ ☐ ☐ ☐ ☐

Birthdate: _____ Marital Status:(circle one):

Address:_____ City:_____
(street or P.O.Box)

State:_____ Zip:_____ Home Phone: _____

Employment Status:

Occupation:_____

Employers name:_____

Employers address:_____ City,State,Zip:_____

Work Phone:_____(ext)____ Other phone (cell, etc):_____

Primary Insurance

Insurance Company:_____Phone:_____

Group name or number:_____ Insured ID #:_____

Policy holder (circle one) : Patient ☐ Other ☐

Name of policy holder (if other than patient):_____

Relationship of the patient to the policy holder:_____

SS# (policy holder):_____Birthdate (policy holder)_____

Name and address of employer of policy holder:_____

_____

(Please have a copy of your insurance card for the receptionist at your visit)

Secondary Insurance

Insurance Company:_____Phone:_____

Group name or number:_____ Insured ID #:_____

Policy holder (circle one) : Patient ☐ Other ☐

Name of policy holder (if other than patient):_____

Relationship of the patient to the policy holder:_____

SS# (policy holder):_____Birthdate (policy holder)_____

Name and address of employer of policy holder:_____

_____

(Please have a copy of this insurance card for the receptionist at your visit)

Referral Information

Who referred you to Dr. Johns?_____

Address:_____ Phone:_____

Please Read

Notice of Privacy Practices

Texas Health Care, P.L.L.C. (TCH) and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in every TCH office. A copy is available from every office and is available for download at DAJMD.com. We would like your acknowledgement that you have been advised of this notice and it has been made available to you.

Assignment of Benefits

I hereby assign, transfer, and set over to THC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric, and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

Appointment of Authorized Representative

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____

(signature)

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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