Pure Spring Medical 660 N. Central Expy Ste 640, Plano TX 75074 (972) 792-7777 PureSpringMedical.com

TYPE OF VISIT: (check one)

- ☐ On-job injury: (do not check "Insurance" if you are injured at work)
- ☐ Private Pay: I will be paying in full, today, at the time of services
- ☐ Insurance: I will present my insurance ID card at check-in for approval

PAYMENT METHOD: (check one)

Payment made today will be paid by:

- ☐ Cash
- ☐ Visa / MasterCard / Discover

PATIENT NAME AND INFO:

Patient Last Name: _____ **First Name:** _____ **Middle:** _____

Address: _____ **APT** _____ **Primary phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Other phone:** _____

Gender: ☐ Male ☐ Female **Patient Date of Birth:** _____ **Other phone:** _____

Email (used for web access to labs and appointment reminders): _____

How did you hear about us? ☐ Friend/Relative ☐ Internet ☐ Drive By ☐ Other **Preferred Language:** _____

Preferred Pharmacy name/location: _____

ACCOUNT NAME: (Fill in this portion only if patient is a minor OR if patient is insured through a family member)

If Insurance: This is the **insured Person** (person whose employer offers the Insurance)

If Private Pay: If patient is a minor, then enter parent's or guardian's information here.

Account Last Name: _____ First: _____ Middle: _____

Account Date of Birth: _____ Phone number _____

Patient's Relation to Insured person: ☐ Child ☐ Spouse

Only Primary Insurance will be billed, please make arrangements with primary insurance to forward information to secondary insurance to avoid being billed for remaining amount. (Medicare with Medicaid secondary will usually do this automatically)

EMERGENCY CONTACTS: (**friend/relative to contact, if patient has a medical emergency or it is essential to discuss health**)

ok to discuss health

Name: _____ Relationship: _____ Tel. # _____ ☒ yes ☐ no

Name: _____ Relationship: _____ Tel. # _____ ☒ yes ☐ no

Authorization for treatment, Payment/Insurance, Release of records, Third parties information, Other:

I consent to the administration and costs of medical and surgical procedures, labs, x-ray, and medication which doctors deem necessary. I authorize the release and transfer of records and information regarding my treatment or medical condition to other providers for treatment purposes, to my insurance carrier and any other payor for payment, to my employer if my treatment is related to employment, for other healthcare operations, and as otherwise set out in the **Notice of Privacy Practices**, which I received today. I also received a **Notice Concerning Complaints** which is a part this form. I hereby guarantee payment of all center and physician charges incurred by the above named patient (except for an authorized and qualified work related expense). I understand that there are no guarantees to the results, which may be obtained. I give permission to leave messages regarding my care at the Primary/Other phone # listed above. I understand that I must pay in full today for all services rendered, unless my insurance is accepted and verified. I also understand that if my insurance is accepted and verified, **I must pay all applicable insurance copays, coinsurances and deductibles in full today**.

Private Pay patients: I understand that an insurance claim will not be filed on my behalf, even if I acquire health insurance. I also understand that I may not be able to file insurance claim, depending on the policies of insurance company.

Insurance patients: I understand that send-out (non-instant) labs/tests will be billed separately by the lab company – we do not collect fees for these.

Referrals/Third parties information: I understand that: (1) This practice does not receive any direct or indirect payment for any of the external referrals; (2) Some third parties have displays/brochures in this office – these are for information only and this practice does not approve/disapprove/maintain these. Most of the displays/brochures are displayed without compensation, but for some, this office may receive monetary compensation for the space used; (3) Temporary/part-time doctors are not employees or agents of Pure Spring Medical – they are independent contractors, not controlled by this office.

Telemedicine: If use use this service, you agree to an evaluation over a remote connection, understanding that such evaluation is limited, and may miss important findings that in-person evaluation may pick up.

Labs and Outside Tests Information: I understand that if any labs/tests are ordered by the doctor, **I WILL NEED TO CALL OR COME TO THE OFFICE TO GET ALL OF THE RESULTS**. Unless I am notified earlier, I promise to call or come to the office within five business days after the tests/labs are performed. I understand that **NO CALL DOES NOT MEAN NORMAL RESULTS.**

Patient/Guarantor's Signature: _____ Date _____