Wise County Medical & Surgical Association

1001 W. Eagle Dr. • Decatur, TX 76234 • (940) 627-7443 • Fax (940) 627-7464
1820 O'Neal St., Ste 5 • Gainesville, TX 76240 • (940) 580-3070 • Fax (940) 580-3329

Name:	Date of Birth: DL #:
Address:	Social Security #:
City: State: Zip:	Sex: { } Male { } Female
Phone #	{ } Married { } Single { } Divorced
Primary Physician:	{ } Employed { } Retired { } Other

Employer:	**RESPONSIBLE PARTY:** { } Same as Patient
Address:	Name:
City: State: Zip:	Address:
Work Phone #	City: State: Zip:

Emergency Contact:

Name: Telephone #:

Primary Insurance: **Secondary Insurance:**

Patient Payment Portal

Receive Statements by email

Provides current balance

Pay online with all major credit cards

No charge for this service

Initial Here to Signup: ___________

Patient Passport

Securely send communication to your doctor's office

Review your medical records

Only one patient chart per unique email

(Once an invitation has been sent you will receive an activation email, follow the instructions in the emial to setup your account.)

Initial Here to Signup: ___________

Patient Name: ______________________________ Date of Birth: ______________

Please print your Email:

_______________________@_______________________.__________

Cell Phone Number: _____ - _____ - _______

(Passport users who cannot receive messages must get activation code from staff.)

Copays and Deductibles are due at the time services are rendered.

Signature: **Date:**

Acct. #_______________ **Provider:** _______________

Date:
Office use only. Pt. ID#

REVISED 04/28/2016

WISE COUNTY MEDICAL & SURGICAL ASSOCIATION

1001 EAGLE DRIVE • DECATUR, TX 76234 • 940-627-7443
1820 O'NEAL STREET, SUITE 5 • GAINESVILLE, TX 76240 • 940-580-3070

AUTHORIZATIONS, CONSENTS AND AGREEMENTS FOR THE YEAR 2019

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in judgment of the physician on duty. I understand that no guarantee or assurance has been made as to the result which may be obtained.

FINANCIAL AGREEMENT: I, hereby guarantee payment for services rendered at Wise County Medical & Surgical Association's office. I understand that should any portion of this bill be turned over to a collection agency, WCM&SA reserves the right to add a collection fee of 25%. I further understand that I will be responsible for court costs, attorneys fees, and agency fees which may be incurred in the collection of the account.

ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies to pay directly to Wise County Medical & Surgical Association and any ancillary providers, any benefits and fees under my insurance policy or policies. I understand that this order does not relieve me of my obligation to pay the account. **Also, any balance that is not covered or paid by the insurance company is my responsibility.**

RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize Wise County Medical & Surgical Association, their affiliates or agents, to release any medical information in connection with the services rendered for determination of benefits, or for collection of said benefits from my health insurance carrier(s) and or other parties responsible for payment.

MEDICARE BENEFICIARIES ONLY: I certify that the information given in applying for payment under Title XVII of the Social Securities Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made to Wise County Medical & Surgical Association. I understand that I am responsible for health insurance deductibles and co-insurance.

MEDICARE SUPPLEMENTS: I further authorize the Wise County Medical & Surgical Association to claim and receive benefits through my Medicare supplement.

COMPANY: ______________________________ NAME OF INSURANCE

This authorization includes claims of Medigap Benefits and shall remain in effect until and unless revoked in writing.

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

______________________________	______________	______________________________
Signature of Patient/Responsible Party	Date	Patient Name
______________________________	______________	______________________________
Witness Signature	Date	Patient Account Number

FORM: 201

Wise County Medical & Surgical Association

1001 Eagle Dr • Decatur, TX 76234 • 940-627-7440
1820 O'Neal St, Ste 5 • Gainesville, TX 76240 • 940-580-3070

Jeff B. Alling, MD • Brad D. Faglie, MD • Charle I. Majka, MD
Thomas E. Steffen, MD • Shawn L. White, MD

Acknowledgment 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.

______________________________ ______________________
Patient's Printed Name Date of Birth

______________________________ ______________________
Signature of Patient, if adult, or Parent/Legal Authorized Representative Relationship

____
Witness

Time of Signing: Month: __________ Day ________ Year ______________ Hour______________am/pm

______________________ ______________________
Account # Doctor