



1200 Binz Street, Suite 900  
Houston, TX 77004

Tel: (713)524-9300 Fax: (713) 524-9301

**NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT**

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name Patient's Personal Representative

\_\_\_\_\_  
Signature of Patient's Personal Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

**FOR INTERNAL USE ONLY**

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

- Patient was unable to sign.
- Patient refused to sign.
- Other \_\_\_\_\_

\_\_\_\_ - \_\_\_\_ (Version: As noted on NPP)

\_\_\_\_/\_\_\_\_/\_\_\_\_ (Date: As noted on NPP)

**NOTICE OF PRIVACY  
PRACTICES (NPP)**

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# Communication Consent

In Compliance with federal law, it is the policy of Elite Family Health & Wellness to NOT release confidential, personal, and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cellular telephone, pager and/or fax. We will not leave a message on an answering machine where the recorded message does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone.

I authorize Elite Family Health & Wellness to leave medical information pertaining to my care by following methods. I will assume responsibility to notify Elite Family Health & Wellness whenever this information changes.

**Please list authorized numbers:**

Home Telephone: \_\_\_\_\_ Answering Machine: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Voice Mail: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

I authorize Elite Family Health & Wellness to leave medical information pertaining to my care to the following / person and will assume responsibility to notify Elite Family Health & Wellness whenever this information changes.

**Please list authorized names and numbers:**

Spouse/Significant other: \_\_\_\_\_

Parent: \_\_\_\_\_

Brother/Sister: \_\_\_\_\_

Son/Daughter: \_\_\_\_\_

Friend: \_\_\_\_\_

## **PRIVACY PRACTICE ACKNOWLEDGEMENT**

I have received a copy of the Elite Family Health & Wellness's Notice of Privacy Practices.

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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Guardian Signature (if patient is under 18) \_\_\_\_\_ Date \_\_\_\_\_

## **Consent for Treatment**

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to **Elite Family & Wellness** unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donations; 2) if another individual is accidentally exposed to patient's blood or body fluids, such as through a needlestick ( any such test shall be conducted pursuant to Elite Family Health & Wellness infectious disease protocol);or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Elite Family Health & Wellness.

If any of these situations occur during your treatment period.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_

\_\_\_\_\_

**Elite Family Health & Wellness  
FINANCIAL POLICY**

Thank you for choosing the **Elite Family Health & Wellness** as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

❖ **It is your responsibility to provide us with your most current insurance information.**

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim- regardless of our estimation.
- **IT is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information.
- If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (817)514-5200 or 1-800-555-1429.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a \$5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at the Houston Neuro & Spine Surgery. Failure to accept this certified letter (and/or to pick up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas Law.
- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

## Authorization for Release of Medical Records

### Patient Information (please print)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

X \_\_\_\_\_

Patient Signature

### Release of Medical Records

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

### Send to

1200 Binz Street, Suite 900

Houston, TX 77004

Phone: 713-524-9300 Fax: 713-524-9301

Please send a copy of the following Medical Records only:

\_\_\_ Lab Reports

\_\_\_ Diagnostic Reports

\_\_\_ Consultations

\_\_\_ Immunization Records

\_\_\_ Last clinic notes

Other: \_\_\_\_\_

**BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS**

# **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## **Who Presents this Notice**

This Notice describes the privacy practices of Elite Family Health & Wellness and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Practice. The Practice and the individual health care providers together are sometimes called "the Practice and Health Professionals" in this Notice. While the Practice and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Practice and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at the Practice as a Practice patient or any other services provided to you in a Practice-affiliated program involving the use or disclosure of your health information.

## **Privacy Obligations**

The Practice and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Practice and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Practice and Health Professionals use or disclose your Protected Health Information, the Practice and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

## **Permissible Uses and Disclosures Without Your Written Authorization**

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Practice and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.
- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Practice Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice and Health Professionals.

Use or Disclosure for Directory of Individuals in the Practice. The Practice may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Practice and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Practice and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. Your PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Business Associates. Your PHI may be disclosed to business associates or third parties that the Practice and Health Professionals have contracted with to perform agreed upon services.

Decedents. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. military, the U.S. Department of State under certain circumstances such as the Secret Service or NSA to protect, for example, the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

## **USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION**

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Practice and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Practice and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Practice and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Practice and/or Health Professionals may receive financial remuneration.



Sale of PHI. The Practice and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Practice; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you (“Highly Confidential Information”), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

## **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Practice and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Practice and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Practice and submit the completed form to the Practice. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Practice and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Practice and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Practice and submit the completed form to the Practice. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Practice and submit the completed form to the Practice. Your request will be accommodated unless the Practice and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Practice Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Practice Compliance & Privacy Office will provide you with the correct address for the Director. The Practice and Health Professionals will not retaliate against you if you file a complaint with the Practice Privacy Office or the Director.

#### **Effective Date and Duration of This Notice**

Effective Date. This Notice is effective on **September 23, 2013.**

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Practice and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Practice and on our Internet site at [www.elitefamilydoc.com](http://www.elitefamilydoc.com). You also may obtain any new notice by contacting the Practice Compliance & Privacy Office.

#### **PRACTICE CONTACTS:**

Elite Family Health & Wellness  
1200 Binz Street, Suite 900  
Houston, TX 77004  
Telephone Number: (713)524-9300

Corporate Compliance & Privacy Office  
Tenet Healthcare  
1445 Ross Avenue, Suite 1400  
Dallas, Texas 75202  
E-mail: [PrivacySecurityOffice@tenethealth.com](mailto:PrivacySecurityOffice@tenethealth.com)  
Phone: 1-877-893-8363 ext. 2009  
Ethics Action Line (EAL): 1-800-8-ETHICS



**Patient Information Form**

Last Name, First, Middle: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male/Female: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race \_\_\_\_\_ Pref Language \_\_\_\_\_ Ethnicity \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Patient Employed By: \_\_\_\_\_ Business Address \_\_\_\_\_

Occupation: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Responsible Party Information**

Last Name, First, Middle: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_ Policy/ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Contact# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Person Responsible employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name of dependents on plan: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Contact# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

