PAIN THERAPUETICS PROFESSIONAL ASSOCIATION

Abraham G. Thomas, M.D.
5420 West Loop South, Ste. 4300
Bellaire, Texas 77401

PATIENT INFORMATION

Name: _____ D.O.B. _____Social Security#:_____
Address:_____City:_____State:_____Zip:_____
Home Phone: _____Cell Phone: _____ Work Phone: _____
Sex: Male /_/ Female /_/ Age:___ Marital Status: Single /_/ Married /_/ Divorced /_/ Widowed /_/
Employer: _____Occupation: _____
Address: _____Phone #: _____
Who referred you to Dr. Thomas?_____
In case of an emergency, whom may we notify? _____Ph#:_____ Relation: _____

PRIMARY INSURANCE

Person Responsible for Account: _____
Last Name First MI
Relation to Patient: _____D.O.B.: _____ SS#: _____
Address (if different from patient): _____
Person Responsible Employed by: _____Occupation: _____
Business Address: _____Work#: _____
Insurance Company: _____Phone#: _____
Member ID#: _____Group#:_____ Contact#: _____

SECONDARY INSURANCE

Person Responsible for Account: _____
Last Name First MI
Relation to Patient: _____D.O.B: _____SS#: _____
Address (if different from patient): _____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____Work#: _____
Insurance Company: _____Phone #: _____
Member ID#: _____ __Group#: _____Contact#: _____

WORKERS'COMPENSATION CARRIER

Worker Compensation Carrier: _____Date of Injury: _____
Carrier Address: _____
Phone#: _____Adjuster's Name: _____
Claim#: _____

ASSIGNMENT, AUTHORIZATION AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Abraham G. Thomas all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

I request that payment of authorized Medicare benefits to be made to me or on my behalf to Dr. Abraham G. Thomas for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for these services. I understand hat my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, If "other health insurance" is indicated in item 9of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted forms, my signature authorizes releasing of the information to the insurer or the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier, as full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment in the event that my claim for Worker Compensation benefits is denied.

_____ _____
Patient's Signature Date