Sweetwater Medical Associates, PLLC

16651 Southwest Freeway, #100
Sugar Land, Texas 77479
281/494-4900

Date_____/_____/_____

Please print. All requested information must be supplied.

Patient Information			
Last Name First Middle			Referred by
Social Security Number	Date of Birth	□ Male □ Female □ Single □ Married □ Widowed □ Divorced	
Home Address, **include apartment number if applicable**, City, State and Zip Code			
Home Phone Number / -	Alternate Number / -	Spouse and Contact Phone Number	
We must have the name of at least two emergency contacts listed below for all patients. If under the age of 18 the emergency contacts must be your parent/parents:			
Name	Phone Number / -	Alternate Number / -	Relationship to Patient
Name	Phone Number / -	Alternate Number / -	Relationship to Patient

Patient Employer/Miscellaneous Information		
Name of Employer Occupation/Title		
Address of Employer, **include suite and/or department if applicable**, City, State and Zip Code		
Work Number and Extension / - x	Alternate Number / - x	Drivers License Number and State

Primary Insurance/Insured's Information		
Insurance Group Number	Insurance Company Name	Patient Member ID Number (not the insured's #)
Insured's Last Name First Middle		□ Male □ Female
Insured's Social Security Number	Insured's Date of Birth / /	Insured's Drivers License Number and State
Insured's Home Address, **include apartment number if applicable**, City, State and Zip Code		
Insured's Home Number / -	Insured's Alternate Number / -	Insured's Relationship to Patient □ Spouse □ Parent □ _____
Name of Insured's Employer Insured's Occupation/Title		
Address of Insured's Employer, **include suite and/or department if applicable**, City, State and Zip Code		

Secondary Insurance/Insured's Information		
Insurance Group Number	Insurance Company Name	Patient Member ID Number (not the insured's #)
Insured's Last Name First Middle		□ Male □ Female
Insured's Social Security Number	Insured's Date of Birth / /	Insured's Drivers License Number and State
Insured's Home Address, **include apartment number if applicable**, City, State and Zip Code		
Insured's Home Number / -	Insured's Alternate Number / -	Insured's Relationship to Patient □ Spouse □ Parent □ _____
Name of Insured's Employer Insured's Occupation/Title		
Address of Insured's Employer, **include suite and/or department if applicable**, City, State and Zip Code		

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ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named on this form, including, but not restricted to drugs, medications, lab tests or other studies, which may be used, by the physician and/or his/her qualified designate.

I understand and acknowledge that I am solely responsible for providing the valid and correct insurance information for any services provided by Sweetwater Medical Associates before services are rendered. I also understand by failing to supply said information that I will be entirely responsible for payment in full.

At the time services are rendered I acknowledge and understand: 1) I am fully responsible for cash payment (if self pay or auto accident), co-payment, deductible and/or co-insurance of such services and agree to pay my bill ***at the time services are rendered unless other arrangements are made with the financial department in advance***. 2) That it is my sole responsibility to provide the correct insurance information for the services rendered on any given day in order for Sweetwater Medical Associates to bill my insurance company. 3) Sweetwater Medical Associates will not bill to any insurance provided after services are rendered. 4) Should I fail to provide the correct information at the time services are rendered, I am ultimately responsible for payment in full, before being issued an itemized receipt, and that no contractual adjustments will be honored.

I authorize Sweetwater Medical Associates to release information as required to my insurance or third party payer for the purposes of determining benefits and to process claims for services rendered. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental issues. I also authorize Sweetwater Medical Associates to bill my insurance or third party payer and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of one year or until such as I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Patient Name: _____ Signed: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____/_____/_____