Lone Star Arthritis & Rheumatology Associates, P.C.

General Phone (817) 789-6770
Fax (817) 789-6677

Patient Financial Responsibility

PATIENT INFORMATION

PATIENT NAME Last	First	M.I.	**SOCIAL SECURITY NUMBER**
ADDRESS Street			**DATE OF BIRTH** / **SEX** ☐ Female ☐ Male
City / State / Zip / **HOME PHONE NO.**			**MARITAL STATUS** ☐ Single ☐ Divorced ☐ Married ☐ Widowed
EMPLOYER			**EMPLOYER PHONE NO.**
EMPLOYER ADDRESS			**PATIENT OCCUPATION**
INSURANCE COMPANY	**ID #**		**GROUP #**
SECONDARY INSURANCE COMPANY	**ID #**		**GROUP #**

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.
If patient is a child please indicate if parents are: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

NAME			**SOCIAL SECURITY NUMBER**
ADDRESS Street			**DATE OF BIRTH**
City	State	Zip	**HOME PHONE NO.**
EMPLOYER			**EMPLOYER PHONE NO.**
EMPLOYER ADDRESS			

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	**NAME OF REFERRING PHYSICIAN**

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY Name	**PHONE NO.**
ADDRESS	

I hereby authorize Lone Star Arthritis & Rheumatology Associates, P.C. to release any information in the course of my examination and/or treatment as permitted by law to facilitate treatment, payment, or healthcare. I hereby authorize payment directly to Lone Star Arthritis & Rheumatology Associates, P.C. for surgical and medical benefits, if any, otherwise payable to me under terms of my insurance. I hereby authorize photocopies of this to be as valid as the original.

I am financially responsible for all non-covered services, insurance denials and all services rendered without a referral, if my plan requires a referral for services rendered.

I hereby agree to immediately pay all statements received from Lone Star Arthritis & Rheumatology Associates, P.C. for services rendered. I agree to pay interest on all past due accounts (over thirty days) at the rate of 1.5% per month/18% per annum, if it becomes necessary to put my account in the hands of a collection agency or attorney. I also agree to pay all such costs of collection and reasonable attorney's fees incurred.

Signature:_____ **Date:**_____

PLEASE COMPLETE THIS PATIENT INFORMATION AND AS MUCH OF THE ATTACHED MEDICAL HISTORY AS POSSIBLE BEFORE OFFICE VISIT.