Texas Healthcare, P.L.L.C.
P.O. Box 961205
Fort Worth, Texas 76161-1205

Alan Johns, M.D.

Date

Select One

☐ ☐ ☐ ☐ ☐

Birthdate: ______________________ Marital Status:(circle one):

Address:____ City:__________________
(street or P.O.Box)

State:________ Zip:______________ Home Phone: _________________________

Employment Status:

Occupation:____

Employers name:____

Employers address:______________________ City,State,Zip:______________________

Work Phone:_______________(ext)____ Other phone (cell, etc):_______________

Primary Insurance

Insurance Company:________________________________Phone:________________

Group name or number:_______________________ Insured ID #:_______________

Policy holder (circle one) : Patient ☐ Other ☐

Name of policy holder (if other than patient):__________________________________

Relationship of the patient to the policy holder:_________________________________

SS# (policy holder):__________________Birthdate (policy holder)_________________

Name and address of employer of policy holder:_________________________________

____

(Please have a copy of your insurance card for the receptionist at your visit)

Secondary Insurance

Insurance Company:________________________________Phone:________________

Group name or number:_______________________ Insured ID #:_______________

Policy holder (circle one) : Patient ☐ Other ☐

Name of policy holder (if other than patient):_________________________________

Relationship of the patient to the policy holder:________________________________

SS# (policy holder):________________Birthdate (policy holder)_________________

Name and address of employer of policy holder:_______________________________

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(Please have a copy of this insurance card for the receptionist at your visit)

Referral Information

Who referred you to Dr. Johns?___________________________________

Address:_______________________________________ Phone:________________

Please Read

Notice of Privacy Practices

Texas Health Care, P.L.L.C. (TCH) and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in every TCH office. A copy is available from every office and is available for download at DAJMD.com. We would like your acknowledgement that you have been advised of this notice and it has been made available to you.

Assignment of Benefits

I hereby assign, transfer, and set over to THC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric, and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

Appointment of Authorized Representative

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

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(signature)

Acknowledgement 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.

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