

Patient Information/ Insurance Information

Dallas Ft. Worth Sarcoma Group, PA

Today's Date: _____

Appointment With: Dr. Maale or Dr. Casas

Patient Information

Last Name First Name Middle (Maiden) Nickname

Street Address Suite/Apt. No. City State Zip

Home Phone Cell Phone E-Mail Address

Employer Name Address Phone-Number Position Spouse/Guardian

Medication Allergies Emergency: Contact Name Phone No. Relationship

Insurance Information

Insured's Last Name First Name Middle Date of Birth

Primary Insurance Carrier Policy No. Group No. Date of Birth

Secondary Insurance Carrier Policy No. Group No. Date of Birth

Please Present Card(s) to Front Desk Receptionist with a Picture ID to copy for your records.

DFWSG,PA filing of claims is a courtesy we provide to you for your convenience. Your contract is between you and your Health Insurance Carrier. The insured is ultimately responsible for all services rendered. ***You are responsible to provide current and accurate insurance information. You are responsible for all copays, deductibles, non-covered services, untimely payments or balances denied due to your failure to provide DFWSG with current, complete and accurate information.***

We do not file secondary claims. Please make sure you have arranged with your Primary Carrier to electronically "cross-over" your claim automatically to your Secondary Coverage. Our Billing Dept. will gladly assist you with any questions regarding Secondary Claims.

I consent to services recommended by DFWSG,PA including diagnostic procedures, examinations and treatment that the physician designates and considers to be necessary for the treatment of my conditions.

I certify that I have read all of the above information. I have provided DFWSG with current, accurate information.

Signature

Date

Print Name