GRAPEVINE MEDICAL & SURGICAL CENTER

1501 W. Northwest Hwy., Grapevine, Texas 76051
817-481-5365

WORKER'S COMP REGISTRATION FORM

Date: _____

PATIENT INFORMATION: (Use legal name)

Last name: _____ First Name: _____ Middle Initial: ____

Address: _____City: _____

State: _____ Zip: _____ SS No.: _____ Email: _____

Date of Birth: _____ Age: ___ Sex: ___ Marital Status: _S _M _D Drivers Lic.# _____

Phone: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Emergency Contact Name: _____Emerg. Phone No.: (_____) _____-_____

WORKER'S COMP INFORMATION:

Date of Injury: _____ Nature of Injury: _____

Employer: _____

Employer Address: _____
Street City State Zip

Employer Phone: (_____)_____-_____ Contact Person: _____

Is employer a DWC listed employer? ____Yes ____No Self-Insured? ____Yes ____ No

(To verify employer status: https://txcomp.tdi.state.tx.us/twccprovidersolution/empinfohtml)

Treatment authorized by: _____ DWC form needed? ____Yes ____ No

Work Comp Ins. Carrier: _____ Claim No.: _____

Compensable Injury and ICD-9-CM code if available: _____

Claims Address: _____
Street City State Zip

Carrier Phone no.: (_____) _____-_____ Contact Person: _____

Comments: _____

PLEAS READ AND SIGN BACK OF FORM

WORKER'S COMPENSATION
DISCLOSURES AND CONSENTS

Patient Name: _____ Date of Birth: _____ DOI: _____
First Middle Initial Last

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Grapevine Medical & Surgical Center for services rendered to my dependents or me by the physician or under his or her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Grapevine Medical & Surgical Center is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Grapevine Medical & Surgical Center or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Grapevine Medical & Surgical Center Patient Information Privacy Policy. I hereby authorize Grapevine Medical & Surgical Center or the physician individually to release any of my or my dependent's medical or incidental no-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize a Grapevine Medical & Surgical Center representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Grapevine Medical & Surgical Center to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____
(If different from Patient)

Guarantor Name: _____
Please Print