Amarillo Children's Clinic

#17 Care Circle

Amarillo, TX 79124

Rex Fletcher, M.D. Shari Medford, M.D. Rebecca Scott, M.D. Janice Ray, N.P.

Provider: Patient Chart #:

Patient Name: **DOB:** **Age:**

Address: **SSN:**

City, State & Zip: **Sex:**

Home Ph #:

Siblings:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Responsible Party Information: Married Single Divorced Widowed **Email** _____

Guarantor Name: _____ **DOB:** _____

Address: _____ **SSN:** _____

City, State & Zip: _____ **Sex:** _____

Home Ph #: _____ **Work Ph #:** _____ **Add'l Ph #:** _____

Employer: _____

Address: _____ **City, State & Zip:** _____

Other Responsible Party Information: Married Single Divorced Widowed **Email** _____

Guarantor Name: _____ **DOB:** _____

Address: _____ **SSN:** _____

City, State & Zip: _____ **Sex:** _____

Home Ph #: _____ **Work Ph #:** _____ **Add'l Ph #:** _____

Employer: _____

Address: _____ **City, State & Zip:** _____

Insurance Information:

Primary Insurance: **Policy #:** **Group #:**

Policy Holder: **DOB:**

Address: **SSN:**

City, State & Zip: **Relationship:** _____

Phone: **Employer:**

Secondary Insurance: **Policy #:** **Group #:**

Policy Holder: **DOB:**

Address: **SSN:**

City, State & Zip: **Relationship:** _____

Phone: **Employer:**

If a 24-48 hour notice of cancellation is not given you will be billed.

**********Signature On File**********

By signing below I agree the above information is correct, I take full responsibility for any misinformation given.

* I do hereby give my consient for my child to recieve medical treatment from Amarillo Children's Clinic.
* I authorize the release of any medical information to my insurance carrier.
* I authorize any payment due me by my insurance carrier to be made directly to Amarillo Childrens Clinic for all outstanding charges on my account.
* I understand that I am responsible for all charges incurrd by my dependents or myself and that I am responsible for any charges not covered by my insurance policy.
* I permit a copy of this authorization to be used in place of the original.
* It is patient's responsibility to notify the nurse or doctor if your insurance requires any labs to be done at a specific labatory.

Signature _____ **Date: 3/24/2009**