



TEXAS HEALTH MEDSYNERGIES  
PATIENT REGISTRATION FORM  
DISCLOSURES & CONSENTS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to Texas Health MedSynergies or the physician individually for services rendered to my dependents, or me, by the physician or those under his/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 Texas Health MedSynergies 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 Texas Health MedSynergies or the physician on my behalf.

**AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I certify that I have read and been offered a copy of the Texas Health MedSynergies. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health MedSynergies. or the physician individually to release any of my, or my dependent's medical or incidental nonpublic 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 Texas Health MedSynergies 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 diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Texas Health MedSynergies 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 balances 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 Texas Health MedSynergies physician or those under his/her supervision.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(if different from patient)

GUARANTOR NAME (Please Print): \_\_\_\_\_