NORTEX

REHABILITATION

1005 W. RALPH HALL PKWY., SUITE 207
ROCKWALL, TX 75032
PHONE #972-772-6841 / FAX # 972-772-6842

Name ____ DOB ________________

Address _________________________________ City ____________ Zip _________

Social Security #____

Phone #_________________________ Cell #_______________________________

Nortex Rehabilitation is affiliated with Dr. Les T. Sandknop Family Practice. If you are a patient of this practice, please do not schedule a therapy and doctor's appointment on the same day, because your insurance may deny one of the claims. You will then be held responsible for payment. Please Initial __________

W/C or
Insurance Carrier: __________________________ Group #__________________
Policy Holder: ______________________SS#______________DOB____________
Secondary Carrier: _________________________ Policy# ___________________
Policy Holder: _______________________ SS#_____________ DOB __________

Fiscal Policy:

1. You, the undersigned responsible party, agrees to be responsible for all fees/charges incurred for services provided by this office. We will file your insurance only if the following applies:
   (a) You belong to one of our HMO, PPO, BCBS or other health plans.
2. Payment is expected at time of service. A receipt will be provided for you to file with your insurance company.
3. All accounts not paid within a reasonable time may be referred to a collection agency.
4. We do not get involved in any way with disputes between divorced parents of a child we are treating. If you bring the child for treatment, you are responsible for payment in full for services rendered. We do not bill the other parent. We will, however, provide additional copies of your child's bill should you need it.

I authorize the release of any medical records or other information to process insurance claims for any benefits due my provider. I authorize payment of medical benefits to the provider at this office for services rendered to me. I understand that if the physician is not paid in full by proceeds of any benefits, then this assignment does not release my obligation and liability to the physician for payment of all services and items provided to me.

Signature of Patient OR Patient's Authorized Representative DATE