dba CI Medical Center

(Center for Integrated Medicine)

8278-A Bellaire Blvd.; Houston, TX 77036

https://www.cimedicalcenter.com/

Tel: 713-272-8858 - Fax: 713-995-6142

Please fill out ALL of the information below so that we can verify your insurance benefits. If you have any questions, please do not hesitate to contact us. Thank you.

Please save the form on your computer before filling otherwise the uploaded form will be blank

PATIENT INFORMATION DATE: (mm/dd/yyyy)

Name _____ (First Name) _____ (Last Name) _____ (Middle Initial) Date of Birth _____ (mm/dd/yyyy) Age _____

Address _____ City _____ State _____ Zip Code _____

Phone home _____ Work _____ Cellular _____

Email (required for Lab Results Notification via Web Portal) _____

Driver's License No _____ State _____

Sex ◯ Male ◯ Female ***Marital Status*** ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Occupation _____

Spouse's name (parent's name, if child) _____

Race & Ethnicity ◯ White ◯ Black ◯ Hispanic or Latino ◯ Asian ◯ American Indian ◯ Other: _____

How did your hear about us? ◯ Family ◯ Friend ◯ Internet ◯ Health Plan ◯ Banner ◯ Radio ◯ Other _____

☐ **SELF PAY** (if self pay, skip INSURANCE VERIFICATION section below)

PRIMARY INSURANCE INFORMATION

Name of Carrier _____

Phone Number of Insurance _____

Insured Subscriber ID Number _____

Insured Subscriber Group Number _____

Patient's Relationship to the Insured ◯ Self ◯ Spouse ◯ Child ◯ Other _____

SECONDARY INSURANCE INFORMATION

Name of Carrier _____

Phone Number of Insurance _____

Insured Subscriber ID Number _____

Insured Subscriber Group Number _____

Patient's Relationship to the Insured ◯ Self ◯ Spouse ◯ Child ◯ Other _____

HEALTH HISTORY: INITIAL EXAM

NAME	DATE OF BIRTH (mm/dd/yyyy)

Question	***Response***	
	Yes	*No*
In the last 5 days, have you had a fever above 100.4 F (38 C) AND with respiratory symptoms?	☐	☐
Have you had contact with someone diagnosed with COVID-19?	☐	☐
Do you have any other health conditions such as (diabetes, lung disease, heart disease or pregnancy?)	☐	☐
Are you age 60 and older?	☐	☐
Are you part of an investigation of a cluster or an outbreak of COVID-19?	☐	☐

CONSENT TO MEDICAL TREATMENT

I hereby authorize Center for Integrated Medicine (dba CI Medical Center), its employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the physician may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or physician as to the results of the treatments, examination or otherwise that may be obtained.

ASSIGNMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XVIII of the Social Security Act that may cover professional services rendered to the above name mentioned assignee.

FINANCIAL AGREEMENT

I agree to pay any balance of the charges over and above the above mentioned benefits. It is understood by the undersigned that he/she is financially responsible for charges not covered by this **assignment. AUTHORIZATION TO RELEASE INFORMATION**

I authorize the release of any information to any insurance company or third party payor for the purpose of obtaining payment for services provided. I authorize release of any information to any physicians, skilled facility or other health care facility to which I may be admitted or that is involved in my medical care.

Emergency Contact [I agree to release my protect health information to my emergency contact]	
Name	
Relationship	
Phone Number	

PATIENT / RESPONSIBLE PARTY SIGNATURE:	DATE: (mm/dd/yyyy)

Please upload your completed form via Dropbox link below:
https://www.dropbox.com/request/Na1j2csSjredJYM1PvGE