

The Center for Womens Healthcare

James M Wheeler MD, MPH, JD

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www.thecenterforwomenshealthcare.com

Please Print:

Date: _____

Name: _____ Age: _____ Date of Birth: _____ Place of Birth: _____

Marital Status: _____ TDL Number _____ Social Security Number _____ Race _____

Home Address _____ City _____ State _____ Zip Code _____ Phone _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip Code _____ Phone _____

Pharmacy Phone Number _____ Mobile Phone _____ Email _____

Medical Allergies _____

Insurance and Billing Information

Person Responsible for Payment (If Other Than Patient)

Name _____ Relationship _____

Billing Address _____ City _____ State _____ Zip Code _____

Telephone No. Home _____ Work _____

Primary Medical Insurance

Name of Insurance Company _____ Telephone No. _____

Name of Policy Holder _____ Date of Birth _____ Social Security Number _____

Member Identification Number _____ Group Number/Name _____

Office Charges: I understand and agree that all services rendered to me by Dr. James Wheeler are charged directly to me and that I am responsible for payment at the time the charges are incurred.

Insurance: After my insurance coverage has been verified, I understand that I will be financially responsible for co-payments, co-insurance, and /or deductible amount at the time charges are incurred and I will remain responsible for my account until insurance payments have been made. Insurance companies pay according to what they set as a negotiated fee or usual and customary. These insurance payments may not always be the same as Dr. Wheeler's charges. If your insurance company on the contract basis for a negotiated fee makes payment, you will only be responsible for co-payments, co-insurance and/or deductible amounts of this fee.

Assignment of Insurance Benefits: I hereby authorize direct payment of surgical/medical benefits to Dr. James Wheeler for service rendered by him in person or under his medical supervision.

Authorization to Release Information: I hereby authorize Dr. James Wheeler to release any medical or incidental information that may be necessary for processing claims for financial benefits.

Insufficient Funds Checks: I understand I will be responsible for a \$25.00 service fee for all checks returned by my bank to Dr. James Wheeler's office for insufficient funds.

Patient's Signature (If Under 18 Parent/Guardian) Date
Rev. 06/06/07

Witness Date