Manus Health/The Athlete Stop 17758 Katy Freeway Ste 3 Houston TX 77094.Ph. 281-599-3039 Fax.281-599-3024

Name		**Date of Birth** Month ~ Day ~ Year
Marital Status (select one) [ ] S [ ] M [ ] W [ ] Sep [ ] D	Social **Security #**	**Gender** (select one) Male Female
Street Address		**Apt #**
City	**State**	**Zip Code**
Home Phone	**Cell**	**Work**
Emergency Contact Information Name	**Phone**	**Relationship**

INSURANCE SUBSCRIBER INFORMATION (if not patient)

Subscriber's Name		**Date of Birth**
SS#	**Relationship**	**Phone**
Street Address		**Apt #**
City	**State**	**Zip Code**

The Athlete Stop is dedicated to providing the best possible care for you as a patient and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. For your convenience, we accept Visa, Mastercard, and Discover as well as cash, check or money order.
2. Please keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. The insurance company will pay the doctor directly. If your insurance company does not pay the practice within the reasonable time period, we will have to turn to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay the patient responsibility at the time of your visit. If you are insured with a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
4. We will bill your insurance company for any and all services provided here in the clinic. The patient is responsible for any balance remaining due.
5. Not all insurance plans cover all services provided by the clinic. In the event your insurance plan determines a service to be "not covered", the patient will be responsible for the complete charge. Payment is due upon receipt of a billing statement form from our office.

BY SIGNING BELOW:
**I hereby authorize the release of any medical information necessary to process the medical claims.
** I hereby authorize Dr. Darren Chase to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Dr. Darren Chase (or to the party who accepts the assignment). **I certify that the information I have provided with regard to my insurance coverage is correct. **I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.
** I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. **This "Signature on File" is valid for one year from the date indicated below.

Signature X ______________________________ **Date** ______________
(Patient, Parent, Guardian or Legal Representative)