

Patient Information

Name _____ Today's Date _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Date of Birth _____
 Driver's Licence Number _____ State _____
 Social Security Number _____ Male Female
 Occupation _____ Employer /School _____
 Address _____
 City _____ State _____ Zip _____
 Work Phone _____ email address _____
 Referred By _____ Spouse's Name _____
 Emergency Contact (Who does not live with you)
 Name _____ Home Phone _____ Work Phone _____
 Address _____ City _____ State _____ Zip _____

Marital Status

Date

Married _____
 Single _____
 Separated _____
 Divorced _____
 Widowed _____

Children's Names / D.O.B.
 _____ M F
 _____ M F
 _____ M F
 _____ M F
 _____ M F

Responsible Party

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Social Security Number _____
 Occupation _____ Date of Birth _____
 Employer _____
 Address _____
 City _____ State _____ Zip _____
 Work Phone _____ Relation to Patient _____

Important Notice

Thomas A. Grugle, M.D. is an independent, private practitioner and is not associated with, and does not provide employment or supervision of, any clinic, counseling center, or other practitioner.

Primary Insurance Information

Insurance Company _____ Insured's Name _____
 Address _____ Date of Birth _____
 City _____ State _____ Zip _____ Relation to Insured _____
 Policy Number _____ Group Number _____ Plan Name _____
 Ins. Co. Phone Number _____ Medicare # _____

Secondary Insurance Information

Insurance Company _____ Insured's Name _____
 Address _____ Date of Birth _____
 City _____ State _____ Zip _____ Relation to Insured _____
 Policy Number _____ Group Number _____ Plan Name _____

Briefly describe the reasons you are visiting the office today.

THOMAS A. GRUGLE, M.D.
GENERAL PSYCHIATRY

AUTHORIZATION TO RELEASE INFORMATION

Dr. Grugle would like to send a brief letter to the person or agency that referred you to this office. If you were referred by another physician or other mental health professional, the letter will contain a brief summary of Dr. Grugle's findings and recommendations. If you were referred by anyone else, the letter will simply acknowledge that you were seen and that arrangements for your care were made.

The purpose of the letter is to help your doctor or other therapist care for you, and to thank the referral source for sending you to our offices.

This authorization by you is entirely voluntary. If you would like Dr. Grugle to acknowledge your referral to this office, please fill out the information and sign below.

Patient's Name

I authorize Dr. Grugle to send the letter described above to the person who referred me here (please record that person's name and address below):

Signature of patient or person legally authorized to consent on patient's behalf.

Date

Payment is requested at time of service unless prior arrangements have been made.

FINANCIAL RESPONSIBILITY

I agree to pay Thomas A. Grugle, MD, PA for all charges incurred. I also agree to pay all finance charges (10% per annum), late fees, and/or reasonable attorney and collection fees if my account becomes delinquent. Any legal proceedings occurring as a result of any collection action under this agreement shall be brought in the Dallas County court in Richardson, Texas. Patient hereby waives any right to trial or hearing in any other court. To contact Thomas A. Grugle, MD, PA about this account call (972) 671-3100. This contract is subject in whole or in part to Texas law which is enforced by the Consumer Credit Commissioner, 2601 N. Lamar Blvd., Austin, Texas 78705-4207. Phone (512) 479-1285 or (800) 538-1579. Contact the commissioner relative to any inquiries or complaints.

PRIVACY PRACTICES

A statement of Dr. Grugle's privacy practices is available upon request, or is available online at www.cybercouch.com/privacy.html

CANCELLATION POLICY

Patients who cancel less than 24 hours in advance or do not keep their appointment deprive another patient of using that time. Therefore, **full fee will be charged for any appointment broken or not canceled at least 24 hours before the appointment time. I understand that charges for unkept appointments are not usually covered by insurance and that I alone may be responsible for full payment.**

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

AVISO SOBRE LAS QUEJAS

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Your copayments, deductibles or other fees can be automatically deducted from your MasterCard, VISA, American Express or Discover card. This is optional—fill out this form only if you wish to have the fees you incur automatically deducted by this office.

Recurring Debit Authorization

I hereby authorize Thomas A. Grugle, MD, PA to automatically debit my credit or checking account below for all session fees, copayments, cancellation fees, or other miscellaneous fees incurred by or on behalf of the patient listed below. I understand and authorize that said debits will continue until I submit a written request that they be stopped.

I certify that I am the legal holder of the account listed below and that I have full rights and privileges to use the account.

This authorization does not affect any rights I may have under consumer credit laws or the laws of the state of Texas concerning credit card transactions. This authorization does not relieve me of the obligation to pay to Thomas A. Grugle, MD, PA all monies owed for services rendered but not debited from my credit or checking account.

I agree to promptly tell Thomas A. Grugle, MD, PA if my account information changes or if the account is canceled.

The total amount of monthly debits shall not exceed \$_____ unless I give specific written authorization for a larger debit, and then that authorization will only be valid for the month in which it is given.

Patient Name

Account Name

Account Number

Exp. Date

Signature of Cardholder

Date signed