Andrews Center

TCOMI REGISTRATION FORM

In order to serve you properly, we need the following information. All information is strictly confidential and with the exception of TCOMI and your parole/probation officer. This is due to the fact that this is a TCOMI funded service.

Date: _____ Case No: _____

Legal Name (First Middle Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____

Phone No: _____ Work Phone No: _____

Spouse: _____

How many in household legally and financially responsible for? _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Physicians: _____

SID/TDC No: _____ Parole/Probation End Date: _____

Parole / Probation Officer: _____

Address: _____ Office No: _____

Family Physician: _____ Phone No: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone No: _____

I hereby give my consent for Andrews Center to examine, prescribe, or administer medication, counsel, advise for proper care through routine medical/psychiatric and/or emergency services, to otherwise treat me/my ward as deemed necessary during the course of my involvement with Andrews Center. I understand that I may withdraw this consent at any time. According to Texas statutes: TEX. REV. CIV. STAT., ARTICLE 4495b, SECTION 5.08(h) & RULES 509 & 510, Texas Rules of Civil Evidence and other related laws, we may be required to disclose otherwise confidential information to medical, laws enforcement, and/or other government agencies and/or personnel, and that the confidential information disclosed may include HIV/AIS test results or other information relating to HIV/AIDS.

I understand that I am financially responsible for all charges for services to me, upon TCOMI contract ending 08/31/2002 or before if funds become unavailable.

_____ _____

Consumer Date Legal Guardian Date

_____ _____

Consumer Date Legal Guardian Date