PATIENT INFORMATION DATE: _____

Patient Demographics:

Patient Name: First_____ MI___ Last_____

SS# _____ DOB: _____ Sex: □ M □ F

Address: _____Apt # _____
City_____ St_____ Zip _____

Phone: Home_____Cell_____
Work_____

E-Mail (required for patient portal access) _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined

Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Preferred Language: English_____ Spanish_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from FLM

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School: _____

FINANCIALLY RESPONSIBLE PARTY

- Same as Patient Information (If different, please complete section below)

Name: First_____ MI_____
Last_____

Relationship: Spouse Parent Guardian Other (Please Specify):_____

Address: _____Apt #_____
City_____St_____ Zip _____

Phone: Home_____Cell_____
Work_____

Email Address _____

Employer: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____
Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____
Work_____

REFERRAL SOURCE

□ Friend/Family Member □ Insurance Company □ Newspaper_____□ Magazine _____

□ Web Search □ Practice Website □ Another Physician/Provider _____
□Other_____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

- Do Not Release Information

I authorize Family Life Medical and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Family Life Medical of changes or update. I authorize Family Life Medical to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____
Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Name _____ Relationship_____

Phone _____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION

Primary Insurance_____

ID _____ Group: _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____
Employer_____

Secondary Insurance_____ ID: _____ Group _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____
Employer_____

MEDICATION REFILL

Please call the office, or contact us via the patient portal, for medication refills.

Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. Initials _____

Pharmacy Name_____

Address or Cross Street_____

PRIVACY PRACTICES

Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

Signature_____ Date _____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

- I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment that the clinic may charge a cancellation fee of $25.00.
- I authorize direct payment of my insurance benefits to Family Life Medical for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian.
- I understand that it is my responsibility to know my insurance benefits and whether the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- Family Life Medical or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

Lab / X-Ray / Diagnostic Services:

- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.
- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- I consent to treatment necessary to the care which has been discussed and directed by the provider.

- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment.
- I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Family Life Medical

I have read, fully understand and agree to the above medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment and release of medical information & insurance authorization. I also certify that all the information, provided is complete and accurate.

Patient Name _____

Signature _____Date_____

Authorization to Treat a Minor (Ages 0-18) ***____ Not Applicable (patient is an adult)***

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Family Life Medical to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Family Life Medical of changes or update. I authorize Family Life Medical to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____
Phone_____

Name _____ Relationship_____
Phone_____

Name _____ Relationship_____
Phone_____

Health Information Exchange Authorization

Family Life Medical participates in health information exchanges as described in the Texas Health Resources (physician/clinic/facility name) Health Information Exchange Patient's Frequently Asked Questions document which may be revised at any time.
A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.
I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.
I authorize the above provider to disclose my medical information described above to the HIEs in which FLM participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.
I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE to protect your restriction. This must be done at each HIE participating provider you visit.
I authorize release of my medical information to the Health Information Exchanges in which FLM participates: _____ Yes _____ No
Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Print Patient's Name Date of Birth: _____
Signature of patient or authorized representative_____
Relationship to patient _____ Date_____

A "legally authorized representative" is; 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian or a minor, or 6) a person authorized under the Texas Consent To Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. Written evidence of legally authorized representative status must be presented to the clinic prior to release of any information.