Health@Care

GENERAL CONSENT FORM

Patient Name: ____ **Date of Birth:** ______/______/______

Welcome! Thank you for selecting us as your primary care provider. Our goal is to provide exceptional medical care. We appreciate your confidence in our skills and qualifications. We take a team approach to medicine, which means you may see a Nurse Practitioner, Physician Assistant, Pharmacist, or other members of our health care team. We believe this approach leads to better overall wellbeing and work closely together to keep each other up to date on your health. Our office is open Monday through Friday from 8:00am – 5:00pm with lunch taken from 12:30pm – 1:30pm.

NEW PATIENT APPOINTMENTS: New patients should arrive 30 minutes early to their appointment to allow adequate time for check in, insurance verification, and paperwork processing. New patients who arrive past their appointment time will be rescheduled. If you fail to arrive early to your new patient appointment and your paperwork is not complete you may be asked to reschedule. At your first appointment please bring proof of identification, insurance cards, completed paperwork, and an accurate list of your medications or the medications in their original bottles.

APPOINTMENTS: Patients are seen by appointment only; we are unable to accommodate walk-ins. For problems that require same day attention, our office should be called early in the day. Separate appointments are needed for family members that need to be seen on the same day. Should you find it necessary to cancel or change an appointment, kindly contact our office at least 24 hours in advance. There will be a $25 charge for appointments missed without notice.

EMERGENCIES/URGENT NEEDS: In case of an emergency, always call 911. In case of urgent needs or concerns, there is always a doctor on call and available at our main office number. We ask that you restrict your after-hours calls to urgent situations only.

PRESCRIPTION REFILLS: Refills are issued during regular business hours. When you need a refill please contact your pharmacy, not the office, so they can send us the request as this is the most efficient process for both our office and the pharmacy. For controlled substance prescriptions (i.e. certain medications for ADD or chronic pain) please allow 48 hours advanced notice as these require more time to process.

MEDICAL RECORDS: At your written request we will send a copy of your records to the physician of your choice. There is a charge for this service and a specific form that must be completed. There is no charge or release necessary when you are referred to a specialist.

REFERRALS AND INSURANCE REQUIREMENTS: Many insurance companies and managed care organizations require referrals prior to your visit to a specialist. Please allow 48 hours' notice when you need a referral. We are unable to back date referrals if you fail to notify us of your appointment. Our staff interacts with many insurance companies each with different rules and requirements, it is the patient's responsibility to ensure that all required permissions are obtained prior to treatment.

BILLING AND PATIENT ACCOUNTS: Co-payments and deductibles are to be paid at the time of service. If we are unable to verify your insurance coverage payment for the visit will be expected at the time of service. Please remember insurance is a contract between you and your insurance company and not a substitute for payment. You are responsible for payment of your bill regardless of any determination by your insurance company. There is a $25 fee for all returned checks.

PRIMARY CARE PHYSICIAN: If your insurance company requires that you select a primary care provider, you must select a Health-e-Care physician prior to your appointment or you may be asked to reschedule.

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INSURANCE, DISABILITY, AND PHYSICAL FORMS: We require a prepayment of $10 for all forms including insurance, disability, FMLA, official and camp/school physical forms. Please allow five to seven working days for the forms to be completed. Request for expedited form completion will require a payment of $15 with a turnaround time of 3-5 business days.

NOTICE OF PRIVACY PRACTICES: I have had the opportunity to review the Notice of Privacy Practices for Health-e-Care, which explains how my medical information will be used and disclosed. Their privacy officer, Albert Moreno, is available for questions. I understand that I am entitled to receive a copy of this document.

I acknowledge that I have read or been advised to read the 'Notice of Privacy Practices'   **Patient Initials: ___________**

INVOLVEMENT OF OTHERS IN CARE: I authorize Health-e-Care to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

May we contact you by phone and leave a message about your care?

Primary Phone #: ______________________________

☐ Leave message with contact number only
☐ Leave message with detailed information
☐ Do not leave message

Secondary Phone #: __________________________________

☐ Leave message with contact number only
☐ Leave message with detailed information
☐ Do not leave message

CONSENT FOR TREATMENT: I consent for Health-e-Care to administer treatments, tests, and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives.

Patient Initials: ___________

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Print Name of Patient or Personal Representative

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Signature of Patient or Personal Representative

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AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patients Name________________________________ Former Name______________________

Social Security #______________________________ Date of Birth________________________

Information to be released from:

Name: ____

Address: ____

Information to be released to:

Name: ____

Address: ____

(Please mail if over 25 pages)

Type of information to be released:

Complete Medical Records _________________

Other (please specify) _________________

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** **Date:**

The reasons or purposes for this release of information are as follows:
(must be completed for release to be valid)

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Patient Signature [or parent, guardian or legal representative]

____**Date**__________________________

I understand that you will provide this information within 15 business days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Mailed_____________

Please check the location you are visiting:

☐ 900 Jerome · Suite 400 · Fort Worth, TX · 76104 · Phone (817) 732-6060 · Fax (817) 731-2541

☐ 5801 Oakbend Trail · Suite 200 · Fort Worth, TX · 76132 · Phone (817) 529-9100 · Fax: (817) 529-9106