LUBBOCK FAMILY MEDICINE

New Patient Profile

Who may we thank for referring you? _____

How did you hear about Lubbock Family Medicine? _____

Patient Information:

Name (Last) (First) (Middle)

Address City State Zip Code

Home Phone Cell Phone Social Security Number

Date of Birth Employer Employer's phone and address

Circle One: Married Single Widowed Divorced Separated

In case of emergency please contact:

Name Phone Number Relationship to patient

General Questions:

Would you like us to call you with reminders about appointments, labs, etc.? YES / NO

If so what is the best time to call you? MORNING / AFTERNOON / EVENING

What is the best phone number to reach you? HOME PHONE / CELL PHONE / WORK PHONE

Would you like to be added as part of our web enable program? With this program you can make appointments, send messages to the clinic and confirm your appointments online. YES / NO

If yes, what is your email? _____

May we contact you after your appointment to evaluate the quality of our clinic services? YES / NO

Did you make an appointment for today's visit or did you use our walk-in service? APPT / WALK-IN

***If insurance is under someone other than your self please provide the following information:**

Insured's DOB_____ Insured's Social Security Number_____

Authorizations and Agreements for Treatment

The undersigned hereby makes the following Acknowledgements and Agreements regarding treatment to be provided

1. **Consent to Treatment,** I understand that medical treatment is necessary, and that such medical treatment and procedures will be performed by independent physician, and by the employees of the Clinic. I hereby grant my authorization and consent for such treatment and procedures.
2. **Agreement to Pay for Services**, I acknowledge and accept that no guarantee has been given as to the results these treatments may produce in me. I further acknowledge and accept that any treatment(s) given may not help me and may make my condition worse. For and in consideration of the care and treatment provided to the patient. I promise to pay, or arrange for payment, AT THE TIME OF THIS VISIT all charges due for services rendered to or on behalf of the patient. Payment may be made by cash or credit card.
3. **Consent to Treat by a Physician's Assistant or Nurse Practitioner,** I understand that a Nurse Practitioner or Physician's Assistant that is employed by my physician will visit me. I hereby grant authorization and consent for such treatment.
4. **Assignment and Instruction for Direct Payment to Doctor,** I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to: (Print the name of your insurance company)

Rodney Franklin, M.D.
David Vermillion, M.D.
Michael Mendez, M.D
Christopher Shanklin, M.D.
7008 Indiana Ave
Lubbock, TX 79413
(806) 698-8088

If my current policy prohibits direct payment to medical practitioners, then I also instruct and direct you to make out the check to me and mail it directly to:

Rodney Franklin, M.D.
David Vermillion, M.D.
Michael Mendez, M.D.
Christopher Shanklin, M.D.
7008 Indiana Ave
Lubbock, TX 79413
(806) 698-8088

For the professional and medical benefits and otherwise payable to me under my current insurance policy as payments towards the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to the above name assignee(s).

Also, I have agreed to pay, in a current manner, the balance due of any and all professional and medical service charges over and above any insurance payment. I understand that I am fully financially responsible for all of these charges at all times.

1. **Release of Medical Information,** I authorize the release of any and all information pertinent to my case to any insurance company, adjuster, or attorney involved in this case who makes the request in writing, I have read and agreed to Lubbock Family Medicine's Privacy Policy. Further I authorize the release of my medical information to my personal or referral physician.
2. **Risks,** Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and or diagnostic procedures planned for me. I realize that common to surgical, medical, and or diagnostic procedures is the potential for infection, blood clots in the veins and lungs, hemorrhage, allergic reactions, failure of treatment, and even death.

I have read the above Acknowledgements and Agreements, and fully understand and Agree to them.

Patient Signature _____

Witness Signature _____

Policyholder Signature if other than Patient _____

Date _____

Privacy Policy Notice

I have read and reviewed Lubbock Family Medicine's Notice of Privacy Policy*. I understand that Lubbock Family Medicine holds my privacy in the highest regards. I also understand that in some situations my medical and billing information will be shared with other parties in order to provide complete quality medical care. In addition to the parties mentioned in the Notice of Privacy Policies I also consent for Lubbock Family Medicine to share my medical information with those listed below:

☐ Spouse _____

☐ Other _____

Signature:_____

* A copy of our Privacy Policy may be obtained at the front desk, please feel free to ask us for one.