LUBBOCK FAMILY MEDICINE

PLEASE PRINT CLEARLY

DATE:_____

PATIENT NAME:_____ AKA(also known as):_____

SSN:_____ D.O.B.:_____ SEX: Female ☐ Male ☐

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PRIMARY PHONE#: _____ CELL PHONE #:_____

WORK PHONE #: _____ EXT:_____

EMPLOYMENT STATUS: _____ EMPLOYER NAME: _____

EMAIL ADDRESS: _____

ETHNICITY: (Select one)	RACE: (Select one)		
☐ Hispanic / Latin/ Spanish Origin	☐ Native American/ Alaskan Native	☐ Hispanic/ Latino	☐ White
☐ NOT Hispanic/ Latin/ Spanish Origin	☐ Asian	☐ Native Hawaiin/ Pacific Islander	☐ Other
☐ Decline	☐ Black/ African American	☐ Native Mexican American	

PREFERRED LANGUAGE: (Select one)

☐ English ☐ Spanish ☐ Other:_____

PCP (Primary Care Physician): _____

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATION

IF SELF, CHECK BOX BELOW AND CONTINUE TO EMERGENCY CONTACT SECTION

☐ SELF

NAME: _____

RELATIONSHIP: _____ SSN: _____ D.O.B.:_____

HOME PHONE:_____ WORK PHONE: _____EXT: _____

CELL PHONE : _____

HOME ADDRESS (if different from Patient's address): _____

CITY/ STATE/ ZIP CODE: _____

EMPLOYER NAME: _____ CITY/ STATE/ ZIP CODE: _____

EMERGENCY CONTACT INFORMATION: *PLEASE LIST AT LEAST ONE CONTACT*

PRIMARY CONTACT NAME: _____ RELATIONSHIP: _____

PRIMARY PHONE # : _____ WORK PHONE #: _____

CELL PHONE # :_____

SECONDARY CONTACT NAME: _____RELATIONSHIP: _____

PRIMARY PHONE # : _____ WORK PHONE #: _____

CELL PHONE # :_____

CONSENT TO TREATMENT

I (The patient/ guardian/ legal representative to the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians, nurse practitioners, physician's assistants, and staff of Lubbock Family Medicine.

This consent is valid from this date forward.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY POLICY PRACTICES

I have reviewed Lubbock Family Medicine's notice of Privacy Policy, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

ADVANCED DIRECTIVE LIVING WILL

Do you have an advanced directive/ living will? ☐ Yes ☐ No

If you answered No, would you like more information on Advanced Directives?

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a cellular or other wireless device, you agree that in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you. You expressly consent those methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with this account and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment.

E-STATEMENTS

For any balances due after your visit, you will receive an electronic statement, Lubbock Family Medicine does NOT send out paper statements. Electronic statements will be sent either through our patient portal/ Healow or through SMS Text-to-pay messages on your cell phone. Having access to the patient portal allows you to communicate with Lubbock Family Medicine staff, view labs, and visit notes. You can also schedule, and cancel appointments through the patient portal and the Healow app.

NO SHOW/ LATE CANCELLATION

Failure to cancel your scheduled appointment within 24 hours, or no showing your appointment will result in you being charged a "no show" service fee: Office visit: $25.00, Ultrasound: $75.00

PATIENT RECORD DISCLOSURES

In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The following people may have access to my/patient's information:

Name	Relationship

I certify that I have read the foregoing. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign and accept its terms on his/her behalf.

_____ _____ _____

Patient/ Patient Representative Signature | Relationship to Patient | Date

_____ _____ _____

Witness Signature | Reason Patient is Unable to Sign | Date

Patient Financial Responsibility

It is your responsibility to provide Lubbock Family Medicine with your current Insurance Card and/or referral before services are rendered at every visit. If you do not have your insurance card and/or referral with you at the time of service, you will be asked to re-schedule your appointment for a time when you can provide them.

Lubbock Family Medicine will file a claim with your insurance provider only if we are able to file electronically.

Deductibles, Co-payments, Co-Insurance, and payment for any services not covered by your insurance will be collected at the time of your visit. Lubbock Family Medicine will electronically file a claim with your insurance for the balance under your insurance plan's provisions if your insurance company accepts electronic submissions.

If your insurance company requires claims to be mailed in, you will be responsible for filing your own claim for reimbursement. (The receptionist will let you know prior to your visit if your insurance company has this requirement.) You will be responsible to pay for 100% of charges for your visit at the time of service. You will be provided with the necessary codes to file a claim with your insurance company for reimbursement. It is your responsibility to know your insurance company's preferred method of submitting claims. This information can usually be found on their website or by calling the phone number listed on the back of your insurance card.

We honor all our insurance contracts and take adjustments as we are instructed by our payors. After your insurance pays and the insurance company leaves any part of the balance as your responsibility, the balance will need to be paid in full on or before your next visit.

If you were unable to pay your balance on or before your next visit, you will be given a letter which states that you have thirty days to pay the entirety of your balance, which will include any additional charges incurred on that day's visit. Failure to pay your balance in its entirety within the allotted thirty days will result in your dismissal as a patient from Lubbock Family Medicine.

Uninsured patients will be required to pay a $250 deposit when you check in with the receptionist. If your final balance at checkout is more than your deposit, you will be required to pay the remaining balance at that time. If your balance at checkout is less than your deposit, the remaining amount will be refunded to you at that time.

If you understand and agree with this policy, please sign below.

_____ _____

Signature Date

Consent for Communication

Patients/ Clients frequently request that we communicate with them by phone, voice mail, email, or text. Lubbock Family Medicine respects your right to confidential communication about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication. We will only communicate with you by email or text with your written consent at the email address and phone number you have provided. Please be aware that if you have email account through your employer, your employer may have access to your email.

When you consent to communication with us by email or text you are consenting to communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your PHI may be intercepted by persons not authorized to receive such information, when you consent to communicating with us through phone, voice mail, email, or text. Lubbock Family Medicine will not be responsible for any privacy or security breaches that may occur through voicemail, email, or text communications that you have consented to.

You may choose to limit the type of voicemail, email, or texting communication you have with us if you wish to limit your risk of exposing your PHI to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

**If you choose not to receive email or text communications you, please remember Lubbock Family Medicine does not send out paper statements for balances owed. You will instead be notified of any balance at your next appointment. You will be given 30 days after notification to pay the balance.*

☐ I do not consent to any voice mail, email, or texting communication.

☐I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my PHI only by the means (check all that you consent to)

☐ Email
☐ Text
☐ Voice mail

☐I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means.

(Check all that you consent to)

☐ Email
☐ Text
☐ Voice mail

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to communicate through: _____

Patient Signature: _____Date: _____

Authorized Representative/Guardian Signature: _____Date: _____

ALTERNATIVE CONSENT FOR MINOR BY NON-PARENT

The purpose of this Alternative Consent Form is to ensure efficient and timely execution of medical advise and treatment plans, the goal of which is to serve the best interest of the minor. Under certain circumstances consent may be given to other parties with the express written consent below.

AUTHORIZATION TO TREAT A MINOR

I, _____, the parent/ legal guardian, give my consent for the following people to seek medical care the below listed child/children in the event I or another parent/ guardian are unable to be present for the appointment.

Name of Minor:_____ Date of Birth:_____

Name of Minor:_____ Date of Birth:_____

Name of Minor:_____ Date of Birth:_____

Name of Minor:_____ Date of Birth:_____

Consent Granted To:

Name:_____ Relationship to Minor:_____

Name:_____ Relationship to Minor:_____

Name:_____ Relationship to Minor:_____

Name:_____ Relationship to Minor:_____

I acknowledge that in order for Lubbock Family Medicine to administer vaccines/ injections or other treatment to my child in my absence, I must give my permission. I am aware that I have the right to withdraw my consent for any reason and at any time upon written notice of this desire. I hereby state that I have read and understand this consent.

_____ _____

Signature of Parent or Legal Guardian Date