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PATIENT CONSENT AND AUTHORIZATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

CONSENT TO TREAT

I, _____ (Patient name) give permission for Your Family Medical to give me medical treatment and I allow Your Family Medical to file for insurance benefits to pay for the care that I receive.

I understand that: ***(Please initial each)***

_____Your Family Medical will have to send my medical records information to my insurance company.

_____I must pay my share of the costs.

_____I must pay for the cost of the services if my insurance does not pain or I do not have insurance.

_____I understand that I have the right to refuse any procedure or treatment.

_____I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ **Date:** _____

Parent or Guardian Name (PRINTED): _____

Parent or Guardian Signature: _____

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PATIENT CONSENT (PHI)

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AND ANTI-DISCRIMINATION POLICY.

I, _____(Patient name), hereby state that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Novice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that, and consent to the following appointment reminders that will be used by the Practice: (a) a postcard mailed to me at the address provided by me; and (b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; (c) text message to my mobile phone.

4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees with a requested restriction, then the restriction is binding on the Practice.

6) I understands that this consent is valid for seven years. I further understand that I have the right to revoke this Consent in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

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7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

ANTI-DISCRIMINATION POLICY

Initials_____ Discrimination or harassment against any member of Your Family Medical (i.e. physicians, nurse practitioners, office staff, or patients) because of age, ancestry, color, disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, gender, gender identity and/or expression, marital or parental status, national origin, pregnancy, race, religion, sexual orientation, veteran's status, or any other categories protected by federal or state law is prohibited and will not be tolerated, nor will any person for those reasons be excluded from the participation in or denied the benefits of any program or activity within Your Family Medical.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (PRINTED) Signature of Individual

_____ _____

Signature of Legal Representative (Attorney-in-Fact, guardian, or parent if a minor) Relationship

Date Signed: _____

Witness: _____ Title:_____

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of patient or representative

_____
Date

_____
Witness (YFM Employee) Title of Witness

List any person(s) you wish to have access to your medical information, including portal access:

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

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FINANCIAL POLICY AGREEMENT

As part of our ongoing commitment to treating our patients with complete courtesy, dignity, and respect, we regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our billing specialists prior to treatment.

INSURANCE AND PATIENT RESPONSIBILITY

Initials_____ Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copays, co-insurance payments, and deductibles for the insurance companies with whom we are contracted. YFM accepts cash, in-state personal checks, Visa, MasterCard, Discover, and American Express. There is a $30.00 service charge for returned checks.

Initials_____ I understand that if I have insurance I am the responsible party and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above. YFM bills participating insurance companies as a courtesy to our patients. Patients are expected to pay their deductible and/or co-insurance/copay at the time of service. ***You must present an insurance card at each visit. If you or your dependent(s) do not present a valid insurance card at the time of your visit, you will be responsible for the visit cost in full.***

PATIENT RESPONSIBILITY

Initials_____ I understand that some, or perhaps all of the services I receive may be non-covered or not considered reasonably necessary by my insurance company. In the event that my insurance company determines a service to be non-covered, I understand that I will be responsible for the service(s) performed. The physicians in the office will be unable to change their normal course of treatment due to non-covered services or limitations of my insurance benefits. Payment for non-covered services will be due at the time of service or upon receipt of a statement from YFM.

PAYMENT ARRANGEMENTS

Initials_____ I understand that patients with an outstanding balance of 30 days or more overdue must make payment arrangements prior to scheduling appointments. Payment plans must be set up by the patient in person and will automatically be deducted from the credit/debit card specified in that arrangement.

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MINOR PATIENTS

Initials_____ Regardless of marital status, YFM will look to the adult accompanying the patient for payment due at the time of service is rendered to the minor patient. If a parent other than the one accompanying the patient to the office is legally responsible for the account, a copy of the court decree with need to be submitted to the office. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. In addition, minor cannot receive medical treatment without the signed consent of a parent or legal guardian.

CLAIMS SUBMISSION

Initials_____ I understand that YFM will submit my claims and assist me in any way they reasonably can to help get my claims paid. I understand that my insurance company may need me to supply certain information directly to them and it is my responsibility to comply with their requests.

NON-PAYMENT

Initials_____ I understand that statement balances must be paid within 30 days to avoid late payment penalty charges. If my account is over 90 days past due, I will receive a letter stating that I have 20 days to pay my account in full. Partial payments will not be accepted unless arranged in advance with a signed payment arrangement in place. I understand that if a balance remains unpaid, YFM may refer my account to a collection agency. Any collection agency fees, in addition to my unpaid balance, will be my responsibility.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

Initials_____ I understand that if I am unable to make an appointment, I must call within 24 hours prior to your appointment time to reschedule. If I fail to notify YFM prior to missing my scheduled appointment, I understand that I will be charged a NO SHOW FEE of $25.00 for an office visit and $50 for a procedure. This must be paid prior to scheduling any future visit. Frequent missed appointments/no show, or chronic rescheduling may result in termination of physician/patient relationship and release from YFM.

Patient Signature or
Authorized Representative:_____

Printed Name of above: _____

Date: _____

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PATIENT AUTHORIZATION FOR MEDICAL DISCLOSURE (BY TELEPHONE OR FAX)

Please fill out this form and give to the Front Desk.

The patient authorizes this clinic to disclose medical information regarding clinical care and diagnoses, including laboratory results and medical history to those listed below: (i.e. family physician, referring physician, family members, attorney, etc.)

Primary Care Physician_____

Telephone _____

Name_____

Telephone _____ Relationship _____

Name_____

Telephone _____ Relationship _____

Name_____

Telephone _____ Relationship _____

I hereby request and authorize YFM to release and send the following information:

☐ Complete Record

☐ Complete Hospital Records

☐ Records from _____ to _____ only.

☐ Records concerning the following conditions only: _____

_____

This consent is in effect until revoked in writing. Our office requires patient consent in writing for all information requests not related to billing requirements.

_____ _____

Name of Patient (PRINTED) **Date**

_____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**