

1960 Family Practice

Conditions of Services

PATIENT _____ DOB _____ ACCT# _____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize 1960 Family Practice to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to 1960 Family Practice for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by 1960 Family Practice, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at 1960 Family Practice.

Patient/Guarantor Signature Date

Consent to Medical Treatment by a Physician Assistant

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a physician assistant. I fully understand that a physician assistant IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a physician assistant are the responsibility of the physician providing the services at 1960 Family Practice both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients

Patient/Guarantor Signature Date

Release of Patient Healthcare Information

I hereby authorize 1960 Family Practice to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

Patient/Guarantor Signature Date

Do you have an advanced directive (living will)? _____ Yes _____ No

If yes, please bring a copy into our office for our files.

If no, and you would like information on and advanced directive, please speak with your physician.

The above authorizations are valid unless you specify otherwise or revoke them in writing.