WACO FAMILY MEDICINE

Patient Information Annual Registration

Last Name_____First Name_____Middle Name_____

Address_____Apt#_____

City_____State_____Zip_____

BirthDate_____SSN_____Patient / Guardian E-Mail_____@_____

Home Phone_____Cell Phone_____Employer_____Work Phone_____

Preferred Communication Method: ☐ Phone ☐ Email (MyChart) ☐ US Mail

Preferred Pharmacy: ☐ Waco Family Medicine

☐ Other _____

PREFERRED LANGUAGE

☐ ENGLISH
☐ SPANISH
☐ SIGNING / ASL
☐ OTHER_____

MARITAL STATUS

☐ SINGLE
☐ MARRIED
☐ WIDOWED
☐ DIVORCED

HISPANIC OR LATINO/A ETHNICITY

☐ NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN
☐ YES, MEXICAN, MEXICAN AMERICAN, CHICANO/A
☐ YES, PUERTO RICAN
☐ YES, CUBAN
☐ YES, ANOTHER HISPANIC, LATINO/A OR SPANISH ORIGIN

RACE MARK ALL THAT APPLY

☐ WHITE
☐ CHINESE
☐ FILIPINO
☐ JAPANESE
☐ KOREAN
☐ VIETNAMESE
☐ ASIAN INDIAN
☐ BLACK / AFRICAN AMERICAN
☐ OTHER ASIAN
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ GUAMANIAN OR CHAMORRO
☐ SAMOAN
☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER

SEX AT BIRTH

☐ Male ☐ Female

SEXUAL ORIENTATION

☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN
☐ GAY
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DO NOT KNOW
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY

☐ MALE
☐ TRANSGENDER MAN/ TRANSGENDER MALE/ TRANSMASCULINE
☐ FEMALE
☐ TRANSGENDER WOMAN/ TRANSGENDER FEMALE/ TRANSFEMININE
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS

☐ ACTIVE DUTY
☐ DISCHARGED (VETERAN)
☐ NATIONAL GUARD
☐ RESERVES
☐ NONE

FARM WORKER STATUS

☐ MIGRATORY FARM WORKER
☐ SEASONAL FARM WORKER
☐ NOT A FARM WORKER

IN PUBLIC HOUSING

☐YES ☐ NO

HOUSEHOLD INFORMATION

HOW MANY PEOPLE ARE IN YOUR HOUSEHOLD INCLUDING YOURSELF? _____

WHAT IS YOUR MONTHLY HOUSEHOLD INCOME?_____
☐ I HAVE NO INCOME ($0)
☐ MY MONTHLY INCOME IS $_____
☐ MY YEARLY INCOME IS $_____

HOMELESS STATUS

☐ NOT HOMELESS
☐ DOUBLED UP (LIVING WITH OTHERS)
☐ IN A HOMELESS SHELTER
☐ TRANSITIONAL HOUSING
☐ ON THE STREET
☐ PERMANENT SUPPORTIVE HOUSING (THROUGH MHMR / FAMILY ABUSE CENTER)

PARENT / GUARDIAN / GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) INFORMATION ☐ No change since last visit

Patients under the age of 18 MUST have a Guarantor

RELATIONSHIP TO PATIENT: ☐ SELF ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER

NAME_____BIRTHDATE_____SSN_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____ CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____EMPLOYER_____

PRIMARY **MEDICAL** Insurance

INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____CITY_____STATE_____ZIP_____

PRIMARY **DENTAL** Insurance

INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____ HOME PHONE_____CITY_____STATE_____ZIP_____

WACO FAMILY MEDICINE

Patient Information **Annual Registration**

General Consent to Treat

I hereby consent to any and all treatment that my Waco Family Medicine (hereinafter "WFM") clinician and I agree is necessary for me or for the patient(s) I am guardian for.

I understand and acknowledge that WFM is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at WFM may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students, case discussions, or photographic or video images of care activities involving me or my dependents are allowed for teaching purposes unless specifically denied by me. I understand and acknowledge that certain clinical visits may be delivered by telehealth (video or telephone) services, during which I will not be physically in the same room as my clinician. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, my telehealth visit may be discontinued or converted into an in-person visit.

I further understand that as part of its health care services, WFM personnel and my clinician create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by WFM, as described in the Notice of Privacy Practices. I understand and acknowledge that WFM participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between WFM and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at Waco Family Medicine, WFM's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records on me and/or the patient(s) I am guardian for.

By providing my mobile phone number, I consent to text messages regarding upcoming appointments and other notifications related to my healthcare and services provided by Waco Family Medicine. I understand that there may be text or data charges from my mobile carrier.

NOTICE OF PRIVACY PRACTICES

I hereby understand that I have the right to request a copy of the Waco Family Medicine's Notice of Privacy Practices.

LIMITED ENGLISH PROFICIENCY

The Waco Family Medicine proudly offers certain language assistance to its patients free of charge. We also strive to make reasonable accommodations for its disabled patients.

PHOTOGRAPHY

I consent to the taking of photographic and/or video images for the purpose of identification and documentation of my medical care.

STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby understand I am the person primarily responsible for payment of all charges for services rendered by Waco Family Medicine, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due on demand. I further understand that in addition to such service charges, I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by Waco Family Medicine. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of service rendered, I hereby irrevocably assign and transfer to WFM, all rights, title and interest in benefits payable for services rendered by Waco Family Medicine. I hereby authorize and instruct the insurance company and/or Financial Program to pay directly to Waco Family Medicine all benefits due under the terms of my policy or policies. I understand that my insurance policy/financial program, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by my insurance policy/financial program not to be reasonable and medically necessary for my care.

OUTSIDE DIAGNOSTIC CHARGES

Laboratory testing for specimens/x-rays/CT/ultrasounds obtained at Waco Family Medicine and sent to a radiologist or independent lab will be billed to me directly from that independent facility. There is also a lab handling fee for obtaining lab specimen(s) which is billed through Waco Family Medicine. Upon receiving a statement, I understand that I am to contact that laboratory or radiology company to arrange payment or exchange insurance information. I have been informed in writing and verbally of this. I understand that these diagnostic charges are now my responsibility.

PATIENT /GUARDIAN SIGNATURE

I have read and understand this document.

PATIENT SIGNATURE_____ DATE _____

PARENT/GUARDIAN* SIGNATURE_____ RELATIONSHIP TO PATIENT _____

PRINTED NAME_____

Proof of legal guardianship (MAY) be required

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