

Last Name		First Name			Middle Name
Address		Apt#	City	State	Zip
Birthdate	SSN	Patient/ Guardian E-Mail			
Preferred Communication Method: <input type="radio"/> Phone <input type="radio"/> US Mail <input type="radio"/> Email (MyChart)			Home:	Cell:	
Employer:	MINOR PATIENT: List of all adults who have legal rights for this child				
Work Phone:	Full Name	Date of Birth	Relationship to Child	Lives with child?	
				Yes / No	
Preferred Pharmacy:				Yes / No	
<input type="radio"/> WFM: Central <input type="radio"/> WFM: S18th				Yes / No	
<input type="radio"/> WFM: Hillsboro <input type="radio"/> Other:				Yes / No	

SEX AT BIRTH <input type="radio"/> Male <input type="radio"/> Female	PREFERRED LANGUAGE <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Signing / ASL <input type="radio"/> Other	MARITAL STATUS <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced	VETERAN STATUS <input type="radio"/> Active Duty <input type="radio"/> Discharged (Veteran) <input type="radio"/> National Guard <input type="radio"/> Reserves <input type="radio"/> None	FARM WORKER STATUS <input type="radio"/> Migratory Farm Worker <input type="radio"/> Seasonal Farm Worker <input type="radio"/> Not a Farm Worker
SEXUAL ORIENTATION <input type="radio"/> Straight <input type="radio"/> Lesbian <input type="radio"/> Gay <input type="radio"/> Bisexual <input type="radio"/> Something else <input type="radio"/> I do not know <input type="radio"/> Choose not to disclose	HISPANIC OR LATINO/A ETHNICITY <input type="radio"/> Not Hispanic, Latino/a, or Spanish-origin <input type="radio"/> Yes, Mexican, Mexican American, Chicano/a <input type="radio"/> Yes, Puerto Rican <input type="radio"/> Yes, Cuban <input type="radio"/> Yes, another Hispanic, Latino/a or Spanish origin <input type="radio"/> Yes, Hispanic, Latino/a, or Spanish-origin, Combined <input type="radio"/> Unreported/ Chose Not to Disclose Ethnicity	RACE (Check all that apply) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Japanese <input type="checkbox"/> Black / African American <input type="checkbox"/> Korean <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Other Asian <input type="checkbox"/> Unreported /Chose not to disclose race <input type="checkbox"/> Native Hawaiian		
GENDER IDENTITY <input type="radio"/> Male <input type="radio"/> Transgender man / transgender male <input type="radio"/> Female <input type="radio"/> Transgender woman / transgender female <input type="radio"/> Not listed <input type="radio"/> Choose not to disclose	IN PUBLIC HOUSING <input type="radio"/> Yes <input type="radio"/> No	HOMELESS STATUS <input type="radio"/> Not homeless <input type="radio"/> Doubled up (living with others) <input type="radio"/> In a homeless shelter <input type="radio"/> Transitional housing <input type="radio"/> On the street <input type="radio"/> Permanent Supportive Housing (Through MHMR / Family Abuse Center)	HOUSEHOLD INFORMATION How many people are in your household, including yourself? _____ WHAT IS YOUR MONTHLY HOUSEHOLD INCOME? <input type="radio"/> I have no income (\$0) <input type="radio"/> My monthly income is \$_____ <input type="radio"/> My yearly income is \$_____	

PARENT / GUARDIAN / GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) INFORMATION
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: _____

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 _____

GENERAL CONSENT TO TREAT

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

I understand that WFM is a teaching center. My care, and/or the care of the patient(s) I am guardian for, may be provided by a clinician, including but not limited to medical students and resident physicians in training. Teaching services such as direct observation by other clinicians or students, case discussions, or photographic/video images of care activities are permitted for educational purposes unless I specifically decline. I understand that certain visits may be provided by telehealth (video or telephone). I acknowledge the potential risks of using technology, including service interruptions, interception, and technical difficulties. Telehealth services will be provided in accordance with state and federal laws governing clinician licensure and patient privacy. WFM may use technology-assisted clinical tools to support, but not replace, clinical judgment. If telecommunications or technology are not adequate, my visit may be discontinued or converted into an in-person visit.

I understand that WFM personnel and my clinician create and maintain a record of care and services provided. Such information may be used or disclosed for the management and delivery of care, as described in the Notice of Privacy Practices. WFM participates in electronic health information exchange programs, including those operating under the Trusted Exchange Framework and Common Agreement (TEFCA), to enhance coordination and patient safety. If I seek treatment from other healthcare facilities or providers participating in these programs, my health information, or that of the patient(s) I am guardian for, may be shared between WFM and those other facilities or providers. These records may include prescription history, mental health treatment, substance use diagnosis or treatment, and/or HIV testing/results, which may become part of the receiving provider’s health record.

By providing my contact information, I consent to receive communications from WFM by secure patient portal, text message, email, or other electronic means for appointment reminders, test results, and care coordination. I understand that WFM takes steps to protect privacy, and that text or data charges may apply.

NOTICE OF PRIVACY PRACTICES

I understand that I have the right to review and request a copy of WFM’s Notice of Privacy Practices and my patient rights and responsibilities at any time.

LANGUAGE ASSISTANCE AND ACCESSIBILITY

WFM proudly offers language assistance services free of charge and strives to make reasonable accommodations for patients with disabilities.

PHOTOGRAPHY AND VIDEO

I consent to the taking of photographic and/or video images for the purpose of identification and documentation of clinical care. I also understand that such images may be used for teaching purposes, and I have the right to have such photographic and/or video images taken.

IDENTIFICATION VERIFICATION

For patient safety, privacy, and accurate billing purposes, I understand that WFM may request and verify photo identification to confirm my identity or that of the patient(s), for whom I am guardian for. This helps ensure accurate medical records, prevent insurance fraud, and protect patient confidentiality.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am primarily responsible for payment of all charges for services rendered by WFM, regardless of any insurance coverage, including Medicare or Medicaid. Payment is due on demand. I understand that I may be charged for multiple services provided on the same day. (For example, WFM offers integrated behavioral health services; this means that many patients are offered the opportunity to see a counselor during the same visit that they see a medical clinician. This may result in additional charges. You have the right to decline these same-day counseling services.) I understand that any payments I make that exceed the charges for an individual visit or service will be applied to any outstanding balance on my patient account and that such overpayments may not be refunded to me unless my account balance is \$0. In addition to service charges, I may be liable for any court costs, attorney’s fees, collection expenses, or interest incurred should collection actions be required. I certify that all patient and financial information provided is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I irrevocably assign to WFM all rights, title, and interest in insurance benefits payable for such services. I authorize payment directly to WFM and understand I am responsible for charges not covered or deemed not medically necessary by my insurer or payer program.

OUTSIDE DIAGNOSTIC CHARGES

I understand that laboratory testing, imaging, or other diagnostic services performed by external facilities will be billed separately by those entities. I will contact those providers directly for billing or insurance questions and I understand that these diagnostic charges are my financial responsibility.

GUARDIANSHIP ATTESTATION

If signing on behalf of a minor or dependent adult, I certify that I am legally authorized to consent to treatment and will notify WFM of any changes in this status.

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 requested*