NORTH TARRANT FAMILY PRACTICE ASSOCIATES

ACKNOWLEDGEMENT

Revision date: January 02, 2024

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

NTFP is furnishing you and the attached notice, which provides information about how NTFP and its physicians may use and/or disclose protected information about you for treatment, payment, healthcare operations and as otherwise allowed by the law. By signing this form, you acknowledge that you have received a copy of Notice of Health information Practices.

Patient/Guardian Signature: _____ Date: _____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians of this medical office to render routine medical care of the patient indicated on this form and to fulfill the orders of the physicians, including consultants associates, and assistants of the physician choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient/Guardian Signature _____ Date: _____

FOR MINORS

If the patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

Patient/Guardian Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to NTFP and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to NTFP. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of NTFP, if any.

OFFICE VISIT POLICY: We reserve the right to charge $50.00 for failure to notify us of a cancellation. This is a direct charge to the responsible party and is not billed to insurance.

It will be your responsibility to verify that we are currently participating on your insurance plan(s) or that a specific service is covered.

PATIENT/GUARDIAN SIGNATURE: _____ DATE

I WILL NOT HOLD NORTH TARRANT FAMILY PRACTICE LIABLE FOR MISSING OR ERRONEOUS INFORMATION CONTAINED ON THIS FORM.

NORTH TARRANT FAMILY PRACTICE ASSOCIATES

PATIENT NAME: _____

EMAIL: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

WHO TO CONTACT

I hereby give permission to North Tarrant Family Practice Associates to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s).

Name		Relationship		Number	
Name		Relationship		Number	
Name		Relationship		Number	

◯ **I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).**

HOW CAN WE CONTACT YOU?

Communication by phone

Home Telephone: ( )		Work Telephone: ( )	
	Okay to leave a message with Detailed information		Okay to leave message with detailed information
	Leave message with call-back Number only		Leave message with call-back number only

Written Communication

	Okay to mail to my home address
	Okay to mail to my work address
	Okay to fax to this number:

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand the Requests for medical information from persons not listed above will require a specific authorization Prior to the disclosure of any medical information.

Patient/Guardian Signature _____ Date: _____