UNIVERSITY OF NORTH TEXAS
HEALTH SCIENCE CENTER AT FORT WORTH
TEXAS COLLEGE OF OSTEOPATHIC MEDICINE

Clinic _____
F.C. _____

Patient Information

Last Name _____ First _____ M.I. _____
Nombre Appellido / Primer Nombre / Inicial

Address _____ City _____ State _____ Zip _____
Dirección / Calle / Apt / Ciudad / Estado / Codigo

Home Phone ( ) _____ Date of Birth _____ Sex M F Age _____ Race _____
Teléfono / Fecha de Nacimiento / Sexo / Edad / Raza

Marital Status S M D W Sep SSN _____ Drivers License No. _____
Estado Civil / Seguro Social / Licencia o I.D.

Place of Employment _____ Work Phone _____
Nombre de Empleo / Teléfono de Empleo

Employer's Address _____ City _____ State _____ Zip _____
Dirección de Empleo / Ciudad / Estado / Codigo

Emergency Contact (other than spouse) _____ Relationship _____ Phone _____
Contacto de Emergencia / Relacion / Teléfono

Address _____ City _____ State _____ Zip _____
Dirección / Ciudad / Estado / Codigo

Responsible Party _____ Relationship _____ Phone _____
Persona Responsable / Relacion / Teléfono de Empleo

Place of Employment _____ Work Phone _____
Nombre de Empleo / Teléfono de Empleo

Date of Birth _____ SSN _____ Sex F M
Fecha de Nacimiento / Numero de Seguro Social / Sexo

Address _____ City _____ State _____ Zip _____
Dirección / Ciudad / Estado / Codigo

Name of Referring Physician _____ Address _____ Phone _____

Primary Insurance Medicare Medicaid HMO PPO Military Other _____
Plan Code _____
Name of Insurance Company _____
Address _____ City _____ State _____ Zip _____
Name of Insured _____ Relationship _____
Plan/Group No. _____ Policy _____
Effective Date _____ Phone No. ( ) _____

Secondary Insurance Medicare Medicaid HMO PPO Military Other _____
Plan Code _____
Name of Insurance Company _____
Address _____ City _____ State _____ Zip _____
Name of Insured _____ Relationship _____
Plan/Group No. _____ Policy _____
Effective Date _____ Phone No. ( ) _____

I authorize the physician to release any information in the course of my examination or treatment and permit payment directly to the physician at his/her election any benefits due for services rendered. I recognize and accept responsibility for any balance remaining alter payment of Duch benefits (excluding Medicaid recipients). By law physicians are required to file Medicare claims for patients. Patients are not allowed to file claims with Medicare.
Patient Signature _____ Date _____

Yo autorizo al médico deprender cualquier información en el curso de mi examinacion o tratamiento y permito pago directamente al médico cualquier beneficio por sus servicios yo reconosco y acepto responsabilidad por cualquier balance después del pago di beneficio (exclusivo pacientes con Medicaid). Se requiere por ley que el médico mande cobrar a Medicare para los pacientes. El paciente no debe mandar cobrar a Medicare.
Firma de Paciente _____ Fecha _____

Print Form

University of North Texas
Health Science Center at Fort Worth
Education, Research, Patient Care, and Service
3500 Camp Bowie Boulevard
Fort Worth, Texas 76107-2699 817-735-2000

CONSENT TO TREATMENT: Each patient of the University of North Texas Health Science Center at Fort Worth (UNTHSC) is treated pursuant to orders of his/her attending practitioner. I understand that UNTHSC is a teaching institution. I give my consent to my attending practitioner or his/her designees to perform or administer all tests and treatment which, in the judgment of such practitioners, are advisable during my visit to UNTHSC.

I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, UNTHSC may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including HIV, with or without my consent. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of the clinic at UNTHSC. I understand the results of tests taken under these circumstances are confidential and do not become a part of my medical record.

RELEASE OF INFORMATION: I authorize UNTHSC to release/obtain information contained in my financial and medical records including diagnosis and test results, to/from (a) any of my treating practitioners, (b) my insurance company or health plan or its representative, or its agents or independent contractors, or (c) any other person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill, or (d) to an person or entity affiliated with UNTHSC for the purposes of administration, billing, collecting, and quality assessment and risk management or to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred. I understand this consent applies to all records created in the course of and relating to my care at UNTHSC.

I release and agree to hold harmless UNTHSC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand UNTHSC cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the services to be rendered to me, I agree to pay for those services. I agree to assign to UNTHSC and any practitioner providing care / treatment to me, the benefits under my insurance policies or prepaid health care plan or other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal responsibility.

THIS IS A LEGAL CONSENT AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING. A photo static copy of this consent form shall be valid and may be used and relied upon with the same effect as the signed original.

Patient/Legally Authorized Person: _____ Date: _____

Print Name and Relationship to Patient: _____

Witness / Translator: _____

University of North Texas Health Science Center at Fort Worth

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the medical practice's Notice of Privacy Practices.

Patient's Name: _____ Date of Birth: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
- Other: _____

Print Name of person signing form if not patient: _____

For Office Use Only:

- Signed form received by:
- Acknowledgement refused:

Efforts to obtain: _____

_____

_____

Reasons for refusal: _____

_____

_____

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For additional information please contact our Institutional Privacy Officer at ext. 0270 or the Director of Regulatory Compliance at ext. 2571.

University of North Texas Health Science Center at Fort Worth
MSRDP dba Physicians & Surgeons Medical Group

Personal Representative

Patient: _____

SS#: _____ DOB: _____

Address: _____ Phone #: _____

City / State _____ Zip Code: _____

Please recognize _____
(print name/relationship) as my personal representative to receive health information about me.)

Please recognize _____
(print name/relationship) as my personal representative to receive health information about me.)

Please recognize _____
(print name/relationship) as my personal representative to receive health information about me.)

Please recognize _____
(print name/relationship) as my personal representative to receive health information about me.)

I understand the potential for information disclosed with to be re-released by me or the recipient of the information. The University of North Texas Health Science Center may not condition treatment on whether or not you sign this authorization.

I understand that I may revoke this personal representative recognition, in writing, at any time except to the extent that action has been taken in reliance on it.

Signed: _____ Date: _____

Witness: _____ Date: _____

If not signed by the patient, please indicate relationship to the patient.

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify) _____

Print Name if not signed by the patient: _____

For office use only

Date received: _____ / Initials _____

Date request rescinded, in writing, by the patient: _____ / initials _____