

(Please Print)

Date \_\_\_\_\_

## Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Sex M \_\_\_ F \_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single Married Widowed Separated Divorced

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

In Case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

## Primary Insurance

Are you currently participating with Medicare? \_\_\_ Yes \_\_\_ NO \_\_\_ Initial

Person Responsible for Account \_\_\_\_\_  
Last First Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contact # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

## Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
(Name of Insurance Company)

and assign directly to **Texas Family Medical and Minor ER Center** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Texas Family Medical and Minor ER Center** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature Relationship Date

**TEXAS FAMILY MEDICAL  
&  
MINOR EMERGENCY CENTER  
1331 NORTHPARK DR  
KINGWOOD, TEXAS 77339  
P: 281-359-5330                      F: 281-359-6117**

THIS PRACTICE IS REQUIRED TO:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction

CONSENT FOR MEDICAL INFORMATION TO BE DISCUSSED WITH FAMILY OR CARETAKER

I, \_\_\_\_\_, give my consent to Texas Family Medical to give medical results, discuss test results, and/or future plans with the following:

(Please check appropriate names)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

CONSENT FOR TEXAS FAMILY MEDICAL TO DISCUSS MY MEDICAL BILLS RELATED TO THIS OFFICE ON MY BEHALF

I, \_\_\_\_\_, give my permission to Texas Family Medical or its representative to speak to my insurance carrier regarding any charges at this office on my behalf.

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&  
MINOR EMERGENCY CENTER  
1331 NORTHPARK DR  
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CONSENT TO TREATMENT FOR TEXAS FAMILY MEDICAL

“I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as accessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a NOTICE OF INFORMATION that provided a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change our notice and practices and prior to implementation will mail a copy of any revised notices to the address I’ve provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice had already taken action in reliance thereon, etc.”

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PATIENT’S SIGNATURE

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DATE

CODE OF CONDUCT

We, the staff of Texas Family Medical have been and continue to be committed to the highest of ethical standards in the conduct of our healthcare and business operations.

We demand of ourselves full compliance with Federal, State, and local laws. We are committed to preventing, detecting, and disciplining any unethical behavior.

We thrive and prosper on our quality medical treatment and outstanding reputation for professional conduct. We create systems and controls to keep ourselves true and true to these standards.

# Texas Family Medical & Minor Emergency Center

1331 North Park Drive  
Kingwood, TX. 77339  
281-359-5330 Fax 281-359-6117

Thank you for choosing Texas Family Medical & Minor ER Center as your healthcare provider. We will need to collect payment at time of service, unless we are a provider with your insurance company. Please be advised that you are responsible for any charges not paid by your insurance company.

If we are not a provider for your insurance company we would be happy to provide all the necessary paperwork to file with your carrier for allowable reimbursement. We look forward to servicing your healthcare needs.

I \_\_\_\_\_ understand that I am financially responsible for all charges whether or not paid by insurance.

## **PAYMENT IN FULL IS DUE AT TIME OF SERVICE**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date