New Patient Registration Form

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Street address: _____ Email address: _____

City, State, Zip: _____ SSN: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: _____

Insurance Company: _____ Group ID: _____ Member ID: _____

Policy Holder's Name: _____Policy Holder's DOB: _____

To meet the requirements for financial assistance, please complete the following:

What is your race? (Check the box that applies) ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ American Indian or Alaska Native ☐ Prefer not to report	**What is your ethnicity?** (Check the box that applies) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to report
Are you a US Veteran? ☐ Yes ☐ No **Are you a farm worker?** ☐ Yes ☐ No If yes: ☐ Migrant or ☐ Seasonal	**Do you live in public housing?** ☐ Yes ☐ No **Are you homeless?** ☐ Yes ☐ No If yes, please check the appropriate description ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street
What is your sexual orientation? ☐ Straight ☐ Gay ☐ Lesbian ☐ Bi-sexual ☐ Other ☐ Unknown ☐ Decline to Answer	**What is your gender identity?** ☐ Male ☐ Female ☐ Transgender Male (FTM) ☐ Transgender Female (MTF) ☐ Unknown ☐ Neither exclusively male nor female ☐ Other ☐ Decline to Answer
Number of people living in your home: _____	**Annual household income**: ☐$0-$25,000 ☐$25,000-$50,000 ☐$50,000-$75,000 ☐$75,000-$100,000 ☐>$100,000

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Preferred method of communication: ☐ Call ☐ Text. ☐ Patient Portal ☐ In Person ☐ Mail

Preferred spoken medical language: ☐ English ☐ Spanish ☐ Other: _____

Do you require translation services? ☐ Yes ☐ No ☐ Language: _____

Emergency contact name: _____ Relationship to patient: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Caregiver name: _____ Phone: _____

ASSIGNEMENT OF BENEFITS

I authorize Healthy Family Services of Texas to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Healthy Family Services of Texas. I certify that the information I have reported regarding my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks or other forms of payment sent to me by my insurance company will be forwarded to Healthy Family Services of Texas to be applied to my account, should a balance exist. This assignment will remain in effect until revoked by me in writing.

_____ Patient/Parent or Legal Guardian Initials

CONSENT TO TREAT

I voluntarily consent to receive medical and health care services provided by Health Family Services of Texas physicians, physician assistants, nurse practitioners, employees and associated health care providers as my physician deems necessary. I understand that such services may include diagnostic procedures, examinations and treatments. I understand that Healthy Family Services of Texas is a teaching site and may have residents and students involved in my care. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend or receive services from Healthy Family Services of Texas, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

_____ Patient/Parent or Legal Guardian Initials

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize Healthy Family Services of Texas and its affiliated providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

_____ Patient/Parent or Legal Guardian Initials

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CONSENT FOR COMMUNICATIONS

I authorize Healthy Family Services of Texas and its affiliates to contact me via automated calls, prerecorded messages, and/or voice or text messages related to my health care. This may include text message appointment reminders and clinic-related notifications, such as flu shot availability or closures. I understand that message and data rates may apply and that messages will be recurring. I also acknowledge and agree that these text messages may contain Protected Health Information (PHI). Text messaging is not a secure method of communication and carries some risk of being read by a third party. I may revoke or withdraw my consent at any time. Such withdrawal of consent must be made in writing.

_____ Patient/Parent or Legal Guardian Initials

CONSENT FOR PHOTOGRAPHY, VIDEO AND AUDIO RECORDING

I consent to Healthy Family Services of Texas taking my image for use in treatment, payment or for health care operations. I understand that my image, including photographs and audio/video recordings will be for the purpose of assisting in my care, payment or health care operations including quality initiatives. I understand that Healthy Services of Texas will own these images. Copies of them may be made available upon request. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information prior to written notice of withdrawal.

_____ Patient/Parent or Legal Guardian Initials

TELEMEDICINE/TELEHEALTH SERVICES

I consent to the use of telemedicine/telehealth services as indicated by the Healthy Family Services of Texas Telemedicine/Telehealth Policy. A written copy will be provided upon request.

_____ Patient/Parent or Legal Guardian Initials

NOTICE OF PAYMENT POLICY

I have received and agree to abide by the Payment Policy. A written copy will be provided upon request.

_____ Patient/Parent or Legal Guardian Initials

PRIVACY PRACTICES CONSENT

I consent to the terms as set forth in Healthy Family Services of Texas's Privacy Practices Policies. A written copy will be provided upon request.

_____ Patient/Parent or Legal Guardian Initials

After Hours Emergency or Urgent Care

I understand that HFST's regular office hours are 8am–5pm, Monday through Friday, excluding major holidays and staff meetings. If I need urgent medical assistance after hours, I can call 972-970-9450 to be connected with the provider on call.

_____ Patient/Parent or Legal Guardian Initials

_____ _____

Patient or Parent/Legal Guardian Signature Date

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