



New Patient Registration Form

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

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: _____

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: _____

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

<p>What is your race? (Check the box that applies)</p> <p><input type="checkbox"/> Native Hawaiian or other Pacific Islander</p> <p><input type="checkbox"/> Black or African American <input type="checkbox"/> Asian</p> <p><input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> Prefer not to report</p>	<p>What is your ethnicity? (Check the box that applies)</p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Not Hispanic or Latino</p> <p><input type="checkbox"/> Prefer not to report</p>
<p>Are you a US Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you a farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: <input type="checkbox"/> Migrant or <input type="checkbox"/> Seasonal</p>	<p>Do you live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please check the appropriate description</p> <p><input type="checkbox"/> Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street</p>
<p>What is your sexual orientation?</p> <p><input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian</p> <p><input type="checkbox"/> Bi-sexual <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Decline to Answer</p>	<p>What is your gender identity?</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (FTM)</p> <p><input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Neither exclusively male nor female <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Decline to Answer</p>



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Patient Name: _____ Date of Birth: _____

Emergency contact name: _____ Relationship to patient: _____

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

Caregiver name: _____ Phone: _____

ASSIGNMENT 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 provide 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

Patient or Parent/Legal Guardian Signature

Date