NORTH TEXAS CARE CLINIC

Consent to Medical Treatment
Consent for Billing and Services Rendered
Acknowledgment of Receipt of Privacy Practices Notice

Patient Name: _____ DOB: _____

Initial: _____ I hereby consent to and authorize the performance of medical or minor surgical procedures, including emergency life-saving measures, which may be considered necessary or advisable by the healthcare providers that include care provided by nurse practitioners and physician assistants of North Texas Care Clinic.

Initial: _____ I authorize payment of medical benefits to North Texas Care Clinic providers or supplier for medical services, to include government assigned benefits. I authorize the release of any medical or other information necessary to process this claim.

Initial: _____ Financial Arrangement: I hereby agree that I am financially responsible for charges incurred at the time of rendered services. I acknowledge that I have received the financial policy. Should my account be referred to an attorney or agency for collection, the undersigned shall pay reasonable attorney fees and collection expenses.

Initial: _____ I hereby acknowledge that I have received the HIPPA Notice of Privacy Practices for Personal Health Information and New Patient Welcome Letter.

_____ _____
Patient Name (Printed) Date

_____ _____
Patient Signature or Patient Representative Relationship

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE _____

ID # _____ POLICY/GROUP # _____ POLICY HOLDER NAME/DOB _____

SECONDARY MEDICAL INSURANCE _____

ID # _____ POLICY/GROUP # _____ POLICY HOLDER NAME/DOB _____