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

Clinic _		
F.C		_

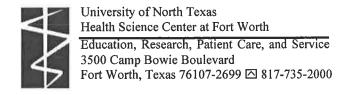
#### Patient Information

ast Name			First				M.I.	
Nombre Appelido			Primer Nombre				Inicial	
A alalyana			City			State		7in
Address Dirección / Calle / Apt			Cludad			Estado		Codigo
, , ,								
							Race	
eléfono		Fecha de Nacim	iento	Sexo		Edad	Raza	1
Marital Status S M D	W Sep	SSN			Drive	s License N	١٥،	
stado Civil		Seguro Social			Licenci	a o 1.D.	-	
Olaca of Employment						Work Pho	no.	
Nombre de Empleo						Teléfono de		
			City			State		Zip
Dirección de Empleo			Ciudad			Estado		Codigo
mergency Contact (other	r than spouse)		Relationship :				Phone	
Contacto de Emergencia			Relacion				Teléfono	
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Address Dirección			City Ciudad			State Estado		Codigo
Pernonsible Party			Relationship				_ Phone	
Persona Responsable			Relacion				Teléfono de E	
Nombre de Empleo			Teléfono de Em	oleo				
Date of Birth			SSN				Sex F	М
echa de Nacimiento		-	Numero de Segu				Sexo	
\ ddraga			City			Stato		7in
Address						Estado		Codigo
Pirección			Ciudad			ESTAGO		Coalgo
)irección						ESTOGO		Coalgo
Dirección  Name of Referring Phys			Cludad				Phone	
Name of Referring Phys	sician		Cludad				Phone	
Name of Referring Phys	sician Medi	icaid	Ciudad HMO I	Addre	ess Milit	ary	Phone Other	9
Name of Referring Phys Primary Insurance	sician	icaid Company	Ciudad HMO I	Addre	ess Milit City	ary	State	Zip
Name of Referring Phys Primary Insurance	sician	icaid Company	Ciudad HMO I	Addre	ess Milit City	ary Relations		Zip
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Name of Referring Phys Primary Insurance Plan Code ————————————————————————————————————	sician	icaid Company icaid Company	HMO I	_ Addre	Milit	Relations Policy Phone N ary Relations	State ship o. ( ) Other State	Zip

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 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



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.

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:			
<ul><li>Signed form received by:</li><li>Acknowledgement refused:</li></ul>			
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	tive to receive health information about me.)
Please recognize	tive to receive health information about me.)
Please recognize (print name/relationship) as my personal representa	tive to receive health information about me.)
Please recognize	tive to receive health information about me.)
I understand the potential for information disclosed information. The University of North Texas Health whether or not you sign this authorization.	
I understand that I may revoke this personal represe extent that action has been taken in reliance on it.	entative recognition, in writing, at any time except to the
Signed:	Date:
Witness:	Date:
If not signed by the patient, please indicate relations  parent or guardian of minor patient  guardian or conservator of an incompet  beneficiary or personal representative of other (specify)	ent patient
Print Name if not signed by the patient:	
For office use only	
Date received: / Initi	als
Date request rescinded, in writing, by the patient:	/ initials