TEXAS FAMILY MEDICINE

Consent to Treat and Health Care Agreement

Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed by my physician or his designee. I understand that Texas Family Medicine may include teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to Texas Family Medicine until revoked by me in writing.

Consent to Release Information:

I acknowledge that Texas Family Medicine may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that the Notice of Privacy Practices provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure, I may be required to pay the entire cost of medical care provided by Texas Family Medicine.

I acknowledge and consent to allow Texas Family Medicine to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other protected health information.

No Show / Cancellation Policy:

To accommodate scheduling of patient care and provide timely appointments, our practice has a No Show/Cancellation Policy: **Any canceled, rescheduled, or no-show appointments for visits or treatments that are not canceled 48 *BUSINESS* hours prior to the appointment time may be charged a $50.00 fee**. *(Monday appointments must be canceled by the previous Thursday; Tuesday appointments must be canceled by the previous Friday.)* Our office reserves time for your care in good faith; please extend the courtesy of contacting our office at least 48 *BUSINESS* hours prior to your appointment time to cancel or reschedule an appointment. **Any canceled, rescheduled, or no-show appointments for diagnostic scans (Imaging) that are canceled less than 1 week prior to the appointment will be charged a $250.00 fee.**

Assignment of Insurance Benefits/Patient Finaneial Responsibility:

I assign and transfer to Texas Family Medicine all rights, title and interest in payments from third-party payers, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance for services rendered. I understand that it is my responsibility to know my insurance benefits and to know which services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that I may be required to pay under my insurance or that Texas Family Medicine is unable to collect from my third-party payer for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys, collection agencies, or file a lawsuit, I agree to pay all patient charges, reasonable attorney fees and collection expenses.

Medicare/Medicaid/Insurance Benefit:

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any Federal or State program-related claims. I request that payment or authorized benefits be made to Texas Family Medicine on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

Lab / X-ray / Ultrasound / Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Texas Family Medicine or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

Consent to Photograph/Digital Imaging:

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that Texas Family Medicine will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

Accidental Exposure of Health Care Worker:

I understand that Texas law provides, and I give consent, that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Notice of Privacy Practice:

I acknowledge receipt of the "Notice of Privacy Practices" from Texas Family Medicine.

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Patient/Responsible Party Signature Date

(Revised 08/25/25)