North Texas Family Health
General Consent Form

2021 revised

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Consent for Medical Treatment.

I give consent to North Texas Family Health, it's staff, providers, and entities associated with the practice, to provide and perform such medical care, tests, diagnostics, procedures, and other services that are deemed necessary or beneficial by the North Texas Family Health for my health and well-being.

Authorization of Payment of Insurance Benefits.

I authorize payment to North Texas Family Health all of the monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care and treatment to cover costs of care and treatment. I hereby authorize the release of any and all medical records about me for the purpose of payment of the services rendered to me.

Signature on File (Medicare Patients only)

I certify that the information given by me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries of carriers, any information needed for this or a submitted Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to North Texas Family Health for services provided by the practice.

Financial Agreement

I agree that in consideration for the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of North Texas Family Health. I understand that, to the extent permitted by law, where insurance or other third-party benefits are insufficient to pay for all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, co-insurance or other fees required by insurer, HMO, or other benefit plan. I understand that if I have not provided North Texas Family Health with accurate and current information regarding my insurer at the time of service, HMO, or other benefit plan/third party payer which provides me with healthcare coverage, I will be personally responsible for the cost of all care rendered by North Texas Family Health. I agree to pay all bills when presented. I understand that there will be additional charges for insufficient funds and that I may not receive any further treatment until my payment(s) have been made in full.

Release of Information

I understand that North Texas Family Health will release my health information to:

- Any requesting healthcare provider for my further diagnosis, care, or treatment or for that provider's payment or healthcare operation purposes
- Any person or entity which may be responsible for billing or collection of claims for medical services or products.

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- Any person or entity which is or may be liable to North Texas Family Health or me for all or part of North Texas Family Health's charges. Including but not limited to, insurance companies, HMOs, or third-party payers.
- Any government agency or other organization responsible for oversight of North Texas Family Health or a third-party payer.
- North Texas Family Health's normal healthcare operations, such as labs, diagnostics, and referrals.

I understand that North Texas Family Health may communicate information, including protected health information, with me through text messages, e-mail messages, and patient portal messages.

I understand, to ensure the continuity of my care and treatment, all North Texas Family Health's providers will have access to the information in my electronic health records.

Name: _____ Today's Date: _____

Signature: _____