



North Texas Family Health

Registration

General Information

Patient Name : _____

Preferred Name : _____ Gender: (Male) (Female) Date of Birth: ____/____/____

Email Address: _____ Primary Languages; _____

Primary Phone Number: (____) ____-____ Social Security Number: ____-____-____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Relation to Patient: _____ Phone Number: (____) ____-____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Financial Information

Method of Payment: (Insurance) (Self Pay)

Insurance Company: _____

Member ID: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Pharmacy information

Name: _____ Phone Number: (____) ____-____

Address: _____ City: _____ State: _____ Zip Code: _____



North Texas Family Health
Annual Physical Examination Form

frontdesk@notexfh.org

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Gender: _____ Age: _____

Medical Conditions/Diagnoses/Significant Health Conditions (Chronic)

Current Medications (Use back of page if necessary) **Preferred Pharmacy** _____

Medication

Dosage

Frequency

Diagnosis

Allergies

Reactions

Onset Date

Social History (circle if applicable)

Tobacco Use Daily Weekly Social Former Use (how long ago) _____ Type Used _____

Alcohol Use Daily Weekly Social Former Use (how long ago) _____ Type Used _____

Marijuana Use Daily Weekly Social Former Use (how long ago) _____ Type Used _____

Recreational Drug Use Daily Weekly Social Former Use (how long ago) _____ Type Used _____

Surgeries



North Texas Family Health

Patient Rights

North Texas Family Health is dedicated to providing you with the best in healthcare, as well as providing you with a positive patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care. For this reason, we want you to have a summary of your rights as a patient.

- You have a right to considerate and respectful care.
- You have the right to participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, gender, age, sexual orientation, disability, and/or source of payment.
- You have the right to receive information about your diagnosis, condition, and treatment in terms that you understand.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences of the refusal.
- You may consent or refuse to participate in experimental treatment or research.
- You are entitled to be free from all forms of abuse or harassment.
- You have the right to make, or have a representative of your choice make, informed decisions about your care.
- You are entitled to information about rules and regulations affecting your care or conduct.
- You have the right to know the names and professional titles of your providers and caregivers.
- You have the right to request a second opinion.
- You have the right to personal privacy and to receive care in a safe environment.
- You have the right to a prompt and reasonable response to any request for services within the capacity of North Texas Family Health.
- You have the right to express concerns or grievances regarding your care to the office.
- The confidentiality of your clinical and personal records will be maintained.
- You have the right to see your medical record within the limits of the law.
- You have the right to an explanation of all items on your bill.



North Texas Family Health

HIPPA PRIVACY RIGHTS

North Texas Family Health is required by applicable federal and state law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law.

We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes.

We may use and disclose medical information about you for the following purposes:

Treatment: We may use your medical information to treat you and/or disclose your medical information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your medical information to obtain payment for services we provide to you.

Healthcare operations: We may use and disclose your medical information in connection with the normal course of operating our practice. Healthcare operations may include quality assessment activities, performance evaluations, conducting training, programs, accreditation, certification, licensing, and/or credentialing activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures of your medical information will only be made with your written authorization or in response to legal requirements such as disaster relief, court orders, suspected abuse, neglect, domestic violence, or in certain instances affecting national security.

You have the following rights with respect to your protected health information:

The right to inspect and copy your protected health information.

The right to request amendments to your protected health information.

The right to receive a list of disclosures of your protected health information for other than treatment, payment, healthcare operations, or pursuant to other authorized disclosures as stated above.

The right to request additional restrictions on the use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement that must be in writing.

If you are concerned that we have violated your privacy rights or disagree with a decision we have made to amend or restrict the use and/or disclosure of your protected health information, you may contact us using the contact details listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

North Texas Family Health

980 W Van Alstyne Pkwy

Van Alstyne, TX 75495

Phone: (903) 712-3627 Fax: (903) 712-0060

Email : frontdesk@notexfh.org

Name : _____

Date : _____

Signature : _____



North Texas Family Health

Financial Policy Form

Insurance, Referrals, and Prior Authorizations

Patients are responsible for providing the office with updated health insurance information. If the insurance on file has been terminated, you will be considered self-pay until new insurance is provided to the office. Patients are responsible for checking whether our office or any specialists needing referrals to are in-network with their health insurance plan. Co-pays are due at time of service.

Certain health insurance providers require a prior authorization or referral for some medications and/or specialist services. North Texas Family Health does not guarantee approval from your insurance provider and patients are responsible for providing records and information needed to process the prior authorization.

Self-pay/Private-pay Accounts

Self-pay/Private-pay accounts are patients without insurance coverage, patients covered by insurance plans in which North Texas Family Health does not participate, or patients without an insurance card on file. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. If there is a discrepancy with our information, the patient will be considered self-pay until otherwise proven. Payment for appointments are due at time of service. Check with the front desk for current self-pay rates.

Outstanding Balances

Beginning January 1, 2026, account balances must be at \$0 **prior to being scheduled**. This includes e-visits and in-person appointments. It is never the intention to cause financial hardship for our patients, only to provide them with the best care possible.

Third Party Billing

We do not do any kind of third-party billing. It is patient responsibility to see reimbursement from third party liability insurance (auto, homeowner, etc.). At your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your health insurance carrier and/or we receive a denial on your claim, you will be responsible for the payment in full.

Missed Appointments & Late Appointments

North Texas Family Health requires 24-hour notice of appointment cancellation. Missed appointments and appointments not appropriately canceled will be charged a no-show fee of \$50. Medication refill and routine follow ups are 10 minute appointments. Being late will result in a missed appointment and will need to be rescheduled. If you know you will not make it to your appointment on time, call the front office and an effort will be made to move your appointment to a later time slot if available.

Three consecutive missed appointments will result in termination from any further care and treatment from North Texas Family Health. Five consecutive cancelled appointments will result in termination from any further care and treatment from North Texas Family Health.

Insufficient Funds and Returned Checks

The charge for insufficient funds or returned checks is \$35. This will be applied to your account in addition to the insufficient funds amount owed for service. You may be placed on a cash-only basis following any returned check.

Medical Record Copies

Patients requesting copies of medical records will be charged:

\$10 for copies placed on a USB drive

\$10 for under 20 printed pages

\$15 for 20 to 49 printed pages

\$20 for 50 to 100 printed pages

\$0.20 per printed page over 100

Attorneys and insurance companies will be charged a \$15 fee, postage, and

\$0.25 per printed page under 100

\$0.30 per printed page over 100

\$20 for an itemized bill

\$20 if records must be delivered within 48 hours of the request

Minors

The parent(s) or guardian(s) is/are responsible for full payment and will receive the billing statements. A signed release to treat will be required for unaccompanied minors.

Regardless of any personal arrangements that a patient may have outside of our office, if you are over the age of 18 years of age and receiving treatment, you are ultimately responsible for the payment of the services rendered. Our office will not bill any other personal party.

E-Visits/Telemedicine Appointments

Patients must be approved for e-visits by a North Texas Family Health provider(s).

Patient account balance must be \$0 to have an e-visit scheduled.

Patients must be seen in office every third appointment in order to have current vitals in chart.

E-visits are scheduled for 10 minutes and reserved for medication refills with no changes.

We reserve the right to change and/or modify the information in this form. This financial policy helps our office to provide quality care to our valued patients. If you have any questions, or need clarification about any of the above policies, please contact the office manager of North Texas Family Health at (903) 712-3627.

Patient Name: _____

Date: _____

Signature: _____

Relationship to patient: _____



North Texas Family Health

Controlled Medication Agreement

I understand and voluntarily agree that

1. Initial medication treatments and refills are scheduled appointments. I will keep and be on time for all my appointments with the provider(s) of North Texas Family Health.
2. I will keep my prescribed medication(s) safe, secure, and out of the reach of children. **If my controlled medication is lost, destroyed, or stolen, I understand that it will not be refilled without a scheduled appointment, and I must submit to a drug test. North Texas Family Health cannot guarantee that the pharmacy will refill the medication due to current laws and regulations.**
3. I will take my medication as instructed and I will not change the way I take it without prior approval from my provider.
4. I must be evaluated and complete all necessary diagnostic testing prior to being prescribed treatment.
5. It is my responsibility to keep up when my medications are due for refill and will call the office no later than five business days before my expected refill.
6. I will treat all staff of North Texas Family Health with respect. **If I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped, and I will be terminated from any further care at North Texas Family Health.**
7. I will not contact the provider(s) or staff outside of office hours to request refills.
8. I have been made aware that schedule II-controlled medications (Adderall, Vyvanse, etc.) can only be prescribed by a licensed physician and that North Texas Family Health cannot motivate, influence, or demand that these prescriptions be rushed or mandated. It is at the discretion of our collaborating physician to determine the promptness and certainty of these prescriptions. Any attempt by patients to influence our providers to refill medication outside of the normal refill window may result in termination of the prescription.
9. Portal messages are the only mode of communication to inquire about prescription progress. Do not call the clinic to inquire about your prescription progress or approval.
10. I am responsible for checking with my pharmacy on the inventory and availability of my prescribed medications. I acknowledge that that my prescription must be canceled prior to requesting a change of pharmacies. Not doing so may result in neither pharmacy providing your prescription. This is not the responsibility of North Texas Family Health.
11. **I will not sell or share my prescribed medication(s) with any other person.** I understand that if I do, my treatment will be discontinued, I will be terminated from any further treatment at North Texas Family Health, and I will be reported for any legal consequences necessary to protect North Texas Family Health, its staff, and providers.
12. I will tell the provider(s) at North Texas Family Health all the medications I take, and I will notify the provider(s) when I get a new prescription from another provider or service. This includes, but is not limited to, dentists, urgent care, emergency departments, and specialists.
13. I will limit my prescriptions to be filled at no more than three pharmacies unless prior approval is made with my provider(s). I understand that it is my responsibility to comply with the pharmacy's policies and procedures, and that North Texas Family Health is not responsible for pharmacy policies.
14. I will not use any medications that are not prescribed to me. I will not use illegal drugs (heroin, cocaine, methamphetamines, ecstasy, etc.) I understand that my use of any illicit drugs would result in my treatment being discontinued, and I may be terminated from further care by my provider(s).
15. I acknowledge that I will be required to participate in routine drug testing. I understand that I can be pulled for random drug testing and/or pill count at the provider(s) discretion. I understand that any missed tests will result in not receiving refills and may be considered noncompliance of treatment.
16. I am responsible for this agreement, and I may be terminated from all further treatment from North Texas Family Health if any of these terms are violated or neglected.

North Texas Family Health makes the following commitments to your care:

1. We will set treatment goals and monitor your progress in obtaining these goals.
2. We will provide alternative treatments when necessary to minimize the potential of developing an addiction to the medications being prescribed.
3. We follow both state and federal regulations and we will routinely evaluate the effectiveness, compliance, safety, and necessity of your treatment.
4. We will work in conjunction with other providers, specialties, and services to provide a consistent, safe, and effective care plan.
5. If we must change or cancel your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We reserve the right to change and/or modify the information in this form. This medication policy helps our office to provide quality care to our valued patients. If you have any questions, or need clarification about any of the above policies, please contact the office manager of North Texas Family Health at (903) 712-3627.

Patient Name: _____

Date: _____

Signature: _____

Relationship to patient: _____



North Texas Family Health

GENERAL CONSENT FORM

Consent for Medical Treatment

I give consent to North Texas Family Health's staff, providers, and entities associated with the practice to provide and perform medical care, diagnostics, procedures, and other services that are deemed necessary or beneficial by North Texas Family Health for my health and well-being. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my healthcare or the healthcare of the person for whom I am duly authorized to make such decisions. This includes the right to refuse medical and surgical procedures.

This consent to treatment may be revoked in writing at any time by the patient or duly authorized agent.

Authorization of Payment of Insurance Benefits

I authorize payment to North Texas Family Health the monies and/or benefits to which I may be entitled from government agencies, insurance carriers, and/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 all necessary 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 of 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 of 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 services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services. This includes deductibles, copayments, co-insurance, and/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, HMO, and/or other benefit plan/third-party payer at the time of service, I will be personally responsible for the cost of all care rendered by North Texas Family Health. Copays are due at the time of service. Self-pay patients are required to pay for services rendered at the time of appointment. 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 further treatment until my payment(s) has 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, and/or treatment as well as for that provider's payment or healthcare operations.

Any person or entity which may be responsible for billing or collection of claims for medical services or products.

Any person or entity which is or may be liable to North Texas Family Health or me for all or part of charges from services rendered. This includes but is not limited to insurance companies, HMOs, and/or third-party payers.

Any government agency or other organization responsible for oversight of North Texas Family Health or a third-party payer.

I understand that North Texas Family Health may communicate information, including protected health information, with me through text messages, email, 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 : _____

Date : _____

Signature : _____



North Texas Family Health

Authorization for Use/Disclosure of Protected Health Information

I authorize release of my medical records as described below to North Texas Family Health.

TYPE OF INFORMATION TO BE DISCLOSED:

____ Entire Medical Record ____ Medical Record for Continuity of Care
____ Financial Record ____ Laboratory Tests
____ Radiology Reports ____ Treatment Summary
____ Medication Record ____ Other: _____

In addition, I authorize that this will include health information relating to (check if applicable)

____ Communicable Diseases (Including HIV and AIDS) ____ Drug/Alcohol Abuse
____ Mental Health Records

COVERED DATES OF SERVICE: This authorization includes the period of healthcare from:

_____ to _____ OR _____ All past, present, and future periods.

Expiration: This authorization will be effective, unless revoked in writing, for one (1) year from today's date or until the date written here: _____

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____
Social Security Number: _____

RELEASE MY MEDICAL RECORDS FROM:

Health Care Provider/Entity: _____

Telephone: _____ Fax: _____

To: North Texas Family Health 980 W Van Alstyne Pkwy Van Alstyne, TX 75495

Phone: (903) 712-3627 Fax: (903) 712-0060

I understand this authorization is voluntary and I may refuse to sign it. I understand that I have the right to revoke this authorization, in writing, at any time. I further understand that this authorization is specific to the types of information and the dates of service listed above.

Patient or Guardian Signature: _____ Date: _____

Relationship to patient (if applicable): ____ Parent or Guardian of minor ____ Court appointed guardian

____ Power of Attorney ____ Executor of decedent's estate