

Notice of Patient Responsibilities

This form is meant to inform you, the patient, as well as your family that in addition to rights, you have responsibilities while undergoing medical care. If there are any questions regarding the contents of this form please notify any staff member.

Keep your Health Care Providers Accurately Informed

You (or your parent or legally designated representative) have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health, including unexpected changes in your condition.

Follow Your Treatment Plan

You (or your parent or legally designated representative) are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care/services and implement the physician's orders and as they enforce the applicable practice rules and regulations.

Keep Your Appointments

You (or your parent or legally designated representative) are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice. You will be charged a fee if you do not cancel 24 hours in advance.

Documentation Fees & Medical Records Charges

Insurance companies do not reimburse documentation fees. You, the patient are responsible for all documentation fees as well as for medical records. These charges vary depending on the amount of the time it takes to complete these forms.

Be Responsible for your Financial Obligations

You (or your parent or legally designated representative) are responsible for assuring that the financial obligations of health care/services are fulfilled as promptly as possible, and for providing information for insurance.

Be Responsible for any decision you Make Not to Follow Your Treatment Plan
You (or your parent or legally designated representative) are responsible for your actions if the physician's instructions are not followed. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

Comply with Rules of this Facility Regarding Patient Care and Conduct of our Visitors

You (or your parent or legally designated representative) are responsible for following practice rules and regulations affecting patient care/services and conduct.

Be Considerate of Others

You (or your parent or legally designate representative) are responsible for being considerate of the rights of other patients and personnel, and for assisting in the control of noise, smoking and the number of visitors. You are also responsible for being respectful of the practice property as well as property of other persons visiting the practice. We will not tolerate any hostility or aggression towards the office staff.

Be Responsible for Your Own Lifestyle Choices

Your health depends not just on your care/services but in the long term, on the decisions you make in daily life. Your are responsible for recognizing the effect of lifestyle of your personal life.

I have read the above patient responsibilities and agree to follow them. I have also been given a copy of these guidelines.

Patient Signature

Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to

Family Health Pro the amount due on my claim, for services to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expenses, I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. A photocopy of this agreement shall be considered as effective and valid as the original.

AUTHORIZATON TO RELEASE INFORMATION

I hereby authorize Family Health Pro - Medical Clinic to release any medical information acquired in the course of my examination or treatment as may be necessary for the completion of my insurance claims to any insurance carrier, hospital or health plan.

NOTICE CONCERING COMPLAINTS

Assistance in filing complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, maybe reported for investigation by calling the following telephone number, 1-800-201-9353.

Patient (Guardian) Signature

Date

Guarantor Signature

Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice Of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized representative (if applicable)

Signature

HIPAA NOTICE OF PRIVACY PRACTICES

I am aware of the HIPAA Notice of Privacy practices for Dr. Valdez's office and the copies of the notice are available for me to take upon request.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS

I give my authorization to release medical/surgical information to the following designated representatives:

Patient initials: _____

_____ My Spouse (Name): _____

_____ My Children (Names): _____

_____ Other (Name): _____

_____ May not be given to anyone other than myself

I hereby authorize medical information to be relayed to me via:

_____ Home Phone #: _____

_____ Cell Phone #: _____

_____ Work Phone #: _____

_____ E-Mail Address: _____

_____ Left on voice mail/answering machine _____

Patient Signature: _____

Date: _____