West Texas Family Medicine

___Self-pay ___Insurance ___Workers' Comp ___Medicare ___Medicaid

Patient Information:

Last Name: _____ First Name: _____ Middle Name: _____

___Male ___Female S.S.#:_____ Marital Status: ___Single ___Married ___Divorced ___Widowed

D.O.B.: _____/_____/_____ Primary Language: ___ English ___Spanish ___Other:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone:(_____)_____ Work Phone:(_____)_____ ext._____

E-Mail:_____ (optional) Employer:_____

Head Of Household: Relationship to Patient:_____

Last Name: _____ First Name: _____ Middle Name: _____

___Male ___Female S.S.#:_____ Marital Status: ___Single ___Married ___Divorced ___Widowed

D.O.B.: _____/_____/_____ Primary Language: ___ English ___Spanish ___Other:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone:(_____)_____ Work Phone:(_____)_____ ext._____

E-Mail:_____ (optional) Employer:_____

Primary Insurance:

Insurance Name:_____

Policy #: _____ Group #:_____ Co-Pay:$_____Deductible:$_____

Policy Holder:_____ D.O.B. _____/_____/_____

___Male ___Female S.S. #:_____ Relationship to Patient: ___ Self ___Parent ___Spouse ___Other

Secondary Insurance:

Insurance Name:_____

Policy #: _____ Group #:_____ Co-Pay:$_____Deductible:$_____

Policy Holder:_____ D.O.B. _____/_____/_____

___Male ___Female S.S. #:_____ Relationship to Patient: ___ Self ___Parent ___Spouse ___Other

Emergency Contact:

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Assignment of Benefits-Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dr. McClanahan, Dr. King, Dr. Watkins, Dr. Horton, Dr. John McClanahan and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize West Texas Family Medicine to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____ Signature:_____

Advanced Practice Nurse/Physician Assistant

Consent for Treatment

WEST TEXAS FAMILY MEDICINE

This facility has on staff an advance practice nurse/ Physician Assistant to assist in the delivery of medical care.

An Advance Practice Nurse/Physician Assistant is not a doctor. AN Advance Practice Nurse/Physician Assistant is a middle level who had received advanced education and training in the provision of health care. An Advance Practice Nurse/Physician Assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. The Advance Practice Nurse/Physician Assistant may treat minor lacerations and other minor injuries.

In addition, by a recent law in the state of Texas, (Oct. 2014), Advance Practice Nurse/ Physician Assistant is limited in terms of the ability to prescribe schedule II medications that require a physicians evaluation and prescription. (Some examples of these medications are: Narcotics, hydrocodone….).

I have read the above, and hereby consent to the services of an Advance Practice /Nurse/Physician Assistant for my health care needs.

I understand that as any time I can refuse to see the Advance Practice Nurse/Physician Assistant and request to see a physician.

Patient name (print): _____ Date: _____

Patient Date of Birth: ___/___/____

Patient Signature: _____

Parent/Guardian (print) _____ Date: _____

Patient's parent /Guardian signature: _____

Witness (optional) _____