NORTH TEXAS
Preferred Health Partners

New Patient Registration Form

Today's Date: _____

Patient Information

Patient Full Name: Last Name First Middle (Maiden)

Address (Street or Box): City State Zip

Home Phone # Work Phone # Cell Phone #

Referred By: Date of Birth Age Sex (check one)
☐ Male ☐ Female

Social Security #	Driver's License #	Email Address

Occupation Employer Employer Address

Marital Status (check one) ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Spouse's Name:

Race (check one) ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other

If Student, Indicate School

If Patient is a Minor, provide Name of Parent(s) or Legal Guardian

Emergency Contact Emergency Contact Phone #

Responsible Party

Guarantor Full Name: Last Name First Middle (Maiden)

Address (Street or Box): City State Zip

Home Phone # Work Phone # Cell Phone #

Sex (check one) ☐ Male ☐ Female Date of Birth Age Patient Relationship to Guarantor

Social Security # Driver's License #

Employer Employer Address

Insurance & Subscriber Information

PRIMARY Insurance Company Phone #

Address (Street or Box): City State Zip

Policy ID # Group # Effective Dates of Policy From: To:

Policy Holder (if other than patient) Date of Birth

Social Security # Relationship to Patient

Policy Holder's Employer Work Phone #

Employer Address: City State Zip

New Patient Registration Form

Insurance & Subscriber Information				
	SECONDARY Insurance Company			Phone #
	Address (Street or Box):		City	State Zip
	Policy ID #	Group #		Effective Dates of Policy From: To:
	Policy Holder (if other than patient)		Date of Birth	
	Social Security #		Relationship to Patient	
	Policy Holder's Employer		Work Phone #	
	Employer Address:		City	State Zip

Acknowledgement of the Receipt of North Texas Preferred Health Partners (NTPHP)
Notice of Health Information Practices

Acknowledgement of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

North Texas Preferred Health Partners (NTPHP) is furnishing you with the attached notice, which provides information about how NTPHP and its physicians[1] may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of NTPHP's Notice of Health Information Practices.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Effective Date of this Notice: 08-04-2015

Consent to Treat & Financial Responsibility

New Patient Registration Form

Consent to Treat

I hereby authorize employees and agents of North Texas Preferred Health Partners (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to North Texas Preferred Health Partners (hereinafter "NTPHP") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or it's employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization my include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to NTPHP. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of NTPHP, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Patient Preferences Regarding Communication of PHI (Patient Health Information)

Preferred Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check one):**

☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ Mailed Letter ☐ Guardian

If the above method of communication is by phone, please check the appropriate box below **(check one):**

☐ Leave a message with detailed information.

☐ Leave a message with a callback number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like to us to call you at a different phone number for a particular test result of if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that North Texas Preferred Health Partners is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like North Texas Preferred Health Partners to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

_____ _____ _____

Contact Name Relationship to Patient Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

_____ _____ _____

Contact Name Relationship to Patient Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

New Patient Registration Form

North Texas Preferred Health Partners is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly form patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Race	**Which category best describes your race?** ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Black ☐ Multiracial ☐ White ☐ Asian (includes Pakistan or Indian origins) ☐ Decline **Race Definitions**: **American Indian or Alaska Native**: A person having origins in any of the original peoples of North and South American (including Central America), and who maintains a tribal affiliation or community attachment. **Black or African American**: A person having origins in any of the black racial groups of Africa. **White**: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian**: A person having origins in any of the original peoples of the Far Eats, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, and the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Multiracial**: A person having more than one or a combination of the above origins.
Ethnicity	**Do you consider yourself Hispanic/Latino?** ☐ Yes ☐ No ☐ Decline
Language	**What language do you feel most comfortable speaking with your doctor or nurse?** ☐ English ☐ Tagalog ☐ Sign Language or other Auxiliary Aid or Service ☐ Spanish ☐ Hindi ☐ Unknown ☐ Vietnamese ☐ Italian ☐ Other _____ ☐ Chinese ☐ Korean ☐ Decline

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**