ARLINGTON FAMILY HEALTH PAVILION

707 N. FIELDER RD. SUITE A
ARLINGTON, TX 76012
817-277-2671
afhp@afhpdr.com

All co pays and balances are due at the time of services are rendered unless prior arrangements have been made with the office manager. Parents completing the following forms for their children, please make sure that you provide us with the correct information that is needed to contact the legal guardian. We will not get in the middle of divorce legalities and any issues regarding balances and payments or past due balances.

Personal Information:

Patients Name: Last:_____ First:_____ MI:____

Gender: ☐ Male ☐ Female
SS#:_____ D.O.B_____ DL#:_____
Address:_____ Apt#:_____
City:_____ State:_____ Zip:_____

Home Phone:_____ ☐
Work Phone:_____ ☐ Please Check
Cell Phone:_____ ☐ Contact Preference
Email:_____ ☐

(Contact preference will allow physicians/staff to leave a detailed message.)

Employed:

☐ Yes ☐ No ☐ Retired ☐ Full Time Student
Place of Employment:_____

Martial Status:

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed
Spouse Name:_____ D.O.B:_____ SS#:_____
Spouses Employer:_____

Emergency Contact:
Name:_____ Relationship:_____ Phone Number:_____

Primary Care Physician:

☐ Dr. Ledesma ☐ Dr. Rodgers ☐ Kayleigh King ☐ Tori Ledesma

Race/Ethnicity:

☐Asian ☐American Indian/Alaskan Native ☐Black or African American
☐Caucasian/White ☐Hawaiian Native ☐Hispanic/Latino
☐Other ☐Do not wish to answer

Language:
Primary:_____ Secondary:_____

Signature:_____ D.O.B:_____ Date:_____

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Insurance Information:

Are you the primary insured? ☐ Yes ☐ No ☐ No Insurance

If your answer was NO, please provide primary's information below:

Name:_____ ☐ Male ☐ Female
Date of Birth:_____ SS#:_____ DL#:_____
Place of Employment:_____ Relationship:_____
ID#:_____ Group#:_____ Provider:_____

If you have secondary insurance and you are not the primary insured please fill out the following:

Name:_____ ☐ Male ☐ Female
Date of Birth:_____ SS#:_____ DL#:_____
Place of Employment:_____ Relationship:_____
ID#:_____ Group#:_____ Provider:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

The privacy rule requires Health Care Providers to take reasonable means to limit the use of disclosure of and request for PHI. We will do all in our means to accomplish the intended purpose. These provisions do not apply to notes or disclosures made in pursuant to an authorized request by an individual. Health Care entities must keep record of PHI disclosures provided below. Uses and disclosures may be permitted without prior consent in case of an emergency. I authorize the release of medical records or financial information necessary to process any claims. I authorize my insurance company if applicable to make payments to AFHP for medical treatment. I also agree that the filling out of any medical claim with insurance company is not guarantee of payment. In the event that my claim is denied, I will be responsible for the balance. There is a filing deadline for every insurance company. Please be aware that if you do not bring a current insurance card within 60 days of your visit you will be responsible for the balance due.

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Authorization & Consent of Medical Information

HIPAA requires a list of all individuals to whom you are granting access to your medical information. This form will allow authorized individuals to receive information regarding appointments, test results, account status and any other information regarding treatment or services provided by our facility.

I allow the following individuals to have access to my medical records:

1._____ 2._____
3._____ 4._____

In case of an emergency I authorize the following individual/s to pick up my prescription:

_____ _____

Would you like us to notify you if any outside source (i.e. life insurance, auto insurance, health insurance companies), is requesting information on your behalf? Please note that if you check "**NO**" we will not notify you **UNLESS** a signed authorization is not present.

□ Yes, Please notify me I do have additional restrictions.
□ No, Do not notify me I don't have any additional restrictions.

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

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Acknowledgement receipt of Arlington Family Health Pavilion Policies and Guidelines

Arlington Family Health Pavilion reserves the right to modify the privacy and guidelines outlined in this notice. This may also be changed at any time if HIPAA makes any changes in their policies.

I've received a copy of the "Policies and Guidelines" for Arlington Family Health Pavilion and also a copy of the "Office Policies and Procedures". I have read and understand the office policies and procedures, the notices of privacy practice, as well as the HIPAA guidelines and procedures.

Patients Name:_____ D.O.B:_____

Patient Signature:_____ Date:_____

Representative Signature:_____ Date:_____

(*Representative required if patient is a minor)*

Representative's Relationship to Patient:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

Signature:_____ D.O.B:_____ Date:_____

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