Mohawk Family Medicine

We are a family medicine clinic offering direct primary care services, where our goal is to promote patient health through convenience and time management. We do not accept insurance of any kind.

Additionally, Dr. Stephens provides the following:

- prescribes controlled substances only when clinically necessary
- hormone replacement therapy
- weight loss services

Office Visits:	
New Patient/extended	$120
Established Patient	$100
Follow-Up Visit	$60

*3% fee added if using credit card *

DPC Membership:	
Age 0-17yrs.	$39/mo
18yrs and older	$49/mo
(Family max of $209/mo)	

atient Information

Name: _____ Male ☐ Female ☐
First Middle Last

Married Status: (choose one) Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

D.O.B_____ Age:_____ SSN#:_____ DL#: _____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Employer:_____ Address:_____Work Phone:_____

Guardian / Spouse Information

Name: _____ Male ☐ Female ☐
First Middle Last

D.O.B_____ Age:_____ SSN#:_____ DL#: _____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Employer:_____ Address:_____Work Phone:_____

Emergency Contact Name: _____ Phone:_____

Signature:_____ **Date:**_____

(Patient OR Parent/Guardian of Minor Patient)

Private Pay Agreement

I UNDERSTAND THAT *MOHAWK FAMILY MEDICINE* IS ACCEPTING ME AS A PRIVATE PAY PATIENT. I WILL BE RESPONSIBLE FOR ANY SERVICES I RECEIVE. THE PROVIDER **WILL NOT** FILE A CLAIM WITH MEDICAID OR ANY PRIVATE INSURANCE FOR SERVICE PROVIDED TO ME.

PAYMENT IS DUE AT THE TIME OF SERVICE

Signature:_____ Date_____

Consent to Communicate via Email & Text

Patient Consent for Email and Text Message Communication

Here at **Mohawk Family Medicine** our main communication is through phone call and or text messaging. Patient Privacy is important to us, and Mohawk Family Medicine would like to communicate with you regarding confirming appointments, referral appointments and return for lab results appointments, which means we need your consent.

Email and text communication will never be used for urgent communication.

Should I wish to withdraw consent I accept that I must give at least 5 working days' notice in writing quoting the email and phone number listed below. I will advise the practice if I change my phone number and understand that a new consent form is required.

I _____ give Mohawk Family Medicine consent to contact me via:

☐ Email and Text Email:_____

☐ Email Only

☐ Text Only Cell Phone: _____

☐ Neither

Patient Name:_____DOB: _____

Signature:_____DATE:_____

Parent of Guardian signing for a child of 17 years old and under, please state your relationship:

_____

Consent must be signed by actual patient or legal guardian.

Mohawk Family Medicine

208 York Ave.

Weatherford, Tx. 76086

TEL: 817-320-5880

RELEASE OF PATIENT INFORMATION CONSENT FORM

I hereby authorize Mohawk Family Medicine to release any of my medical information to the following person/persons:

1._____ Relationship:_____

2._____Relationship:_____

3._____Relationship:_____

PATIENT SIGNATURE:_____DATE:_____

PRINT NAME:_____

WITNESS SIGNATURE:_____DATE:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Print Name

_____

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Privacy Notice, but was unable to do so as documented below.

Date: Initials: Reason: