



# VERITAS FAMILY MEDICINE

3105 Colorado Blvd.  
Denton TX, 76210  
Tel: 940-383- 3444  
Fax: 940-383-2224

www.veritasfamilymedicine.com

Date: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F Marital Status: S D M W Sep

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Business Cell

Employer (Company Name): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Names of Family Members: \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_

### Insurance Information:

Insurance Company: \_\_\_\_\_ Member Service Phone: \_\_\_\_\_

PPO POS HMO Commercial Other ID: \_\_\_\_\_ Group: \_\_\_\_\_

### Insurance Policy Member Responsible Party Information:

Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First MI

Relationship to Patient: \_\_\_\_\_

Employer (Company Name): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Secondary Insurance Information:

Insurance Company: \_\_\_\_\_ Member Service Phone: \_\_\_\_\_

PPO POS HMO Commercial Other ID: \_\_\_\_\_ Group: \_\_\_\_\_

### Secondary Insurance Policy Member Responsible Party Information:

Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First MI

Relationship to Patient: \_\_\_\_\_

Employer (Company Name): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize the release of my medical information necessary to process this claim for payment of insurance benefits to CFMA Denton, PLLC and to obtain the proper information for referral forms. I also authorize the office to obtain insurance information from Medicare regarding any claims submitted on my behalf. I understand I am responsible for all charges that insurance does not pay including non covered procedures.

Patient/Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT CONTACT QUESTIONNAIRE**

I. Please list family members or other persons, if any, whom we may inform about your general condition and your diagnosis:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

II. Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, **if other than your home**:

\_\_\_\_\_  
\_\_\_\_\_

IV. Please list any additional phone numbers, if any, to where you want to receive calls about your appointments, lab and x-ray results, or other health care information, **if other than your home phone number**:

( ) \_\_\_\_\_

V. Can confidential messages be left on your home answering machine or voicemail? \_\_\_\_\_ Yes \_\_\_\_\_ No

VI. If you do not have voicemail, can a confidential message be left at your place of employment? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

# Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we may reasonably can to help get your claims paid. *Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.* Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our physician will only be able to treat you on an emergency basis.
  
8. **Missed appointments.** Our policy is to charge \$25 for missed appointments not cancelled within 24 hours of the appointment time. This policy applies to new and established patients and will be charged to the patient/guarantor, **not** to the patient's insurance. All no-show fees must be paid prior to the next appointment in order to be seen. Family Healthcare reserves the right to terminate the doctor-patient relationship of established patients due to no-shows. New patients who no-show for their appointment will **no** longer be able to schedule with our providers and **will** be billed the No-Show fee. New Patients will be allowed to be seen in Family Healthcare, but **only** after the No-Show fee has been paid. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.  
Thank you for understanding our payment policy. Please let us know if you have questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

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**Signature of patient or responsible party**

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**Date**

NOTICE OF PRIVACY PRACTICES \*

# We Care About Your Privacy

## FAMILY HEALTHCARE

3105 Colorado Blvd., Denton, TX 76210

Telephone: (840) 383-3444

### *Our Pledge Regarding Medical Information*

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

\*These privacy practices are currently in effect and will remain in effect until further notice.

### *Our Legal Duty*

#### **Law Requires Us to:**

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

#### **We Have the Right to:**

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

#### **Notice of Change to Privacy Practices:**

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### *Use and Disclosure of Your Medical Information*

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

#### **For Treatment:**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

#### **For Payment:**

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

#### **For Health Care Operations:**

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

#### **Additional Uses and Disclosures:**

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

#### **Facility Directory:**

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

#### **Notification:**

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

#### **Disaster Relief:**

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

#### **Fundraising:**

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing of information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

#### **Research in Limited Circumstances:**

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

#### **Funeral Director, Coroner, Medical Examiner:**

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

#### **Specialized Government Functions:**

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security

and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:**

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:**

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:**

We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:**

We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:**

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

**Law Enforcement:**

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

**Appointment Reminders:**

We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

**Alternative and Additional Medical Services:**

We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

## Your Individual Rights

### You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer

## Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

### Acknowledgement of Notice of Privacy Practices

I have read and understand the Privacy Practices of Family Health. This form will be placed in your chart for permanent record.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

# Telemedicine Informed Consent



Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
  - a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
  - a. I may revoke my right at any time by contacting Veritas Family Medicine at 940-383-3444.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
  - a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
  - b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
  - c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

\_\_\_\_\_  
Patient/Parent/Guardian Printed Name

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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The Texas Medical Association acknowledges the Texas Medical Association Special Funds Foundation for its support of this document through funds awarded by The Physicians Foundation.



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# Telemedicine Informed Consent



## NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board  
Attention: Investigations  
1801 Congress Avenue, Suite 9.200 (physical address)  
P.O. Box 2018 (mailing address)  
Austin, Texas 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number:

**1-800-201-9353**

For more information, please visit our website at

**[www.tmb.state.tx.us](http://www.tmb.state.tx.us)**

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