Toledo Bend FAMILY MEDICINE
A MEMBER OF THE PREFERRED FAMILY

2421 Worth St
Hemphill, Tx 75948
Phone:409-787-1416
Fax: 409-787-1419

CONSENT FOR TREATMENT _____ **Initial**

I understand various screenings and diagnostic studies may be necessary to diagnose my condition and that I will be given various treatment options following diagnosis. I hereby give Toledo Bend Family Medicine providers and ancillary staff the authority to perform the screenings, diagnostic studies deemed necessary and/or the treatment options of my choice.

I understand that Toledo Bend Family Medicine employs the services of mid-level practitioners (Physician Assistants and Nurse Practitioners) to assist in patient care. I understand that under certain circumstances the physician will not be available and, as such, I will be offered the services of the PA or NP. By circling the answer and my signature below I am indicating my willingness or unwillingness to be treated by a mid-level provider in the event the physician is unavailable. I understand that physician availability is determined by appointment schedule, emergencies, and/or on-call status. If I present to the clinic without an appointment, I will be offered the services of the providers in the clinic of whom may be available, or asked to make an appointment with the physician at another time if not appointment time is available.

****I am Willing to be seen by a mid-level provider in the event a physician is unavailable.** Yes No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

1. Medical or Surgical Permit.
   I, the undersigned or authorized party, hereby consent to medical or surgical procedures, x-ray exam or treatment, drug (oral and/or injectable), and supplies which treating physicians, physician assistants or nurse practitioners deem necessary. I understand that there are inherent risks with any of these procedures.
2. Authorization for release of physician responsibility
   If I should leave before completing my medical or surgical procedures, examinations, or treatment, I hereby release said physician or physician assistant and the clinic of any responsibility for medical condition.
3. Consent for release of medical information
   I hereby authorize Toledo Bend Family Medicine Clinic to furnish to any representative of the insurance company(s) under whose policy of insurance I am entitled to benefits for the payment of expenses of my medical treatment by the clinic with any information desired by said company(s) for the completion of any claims resulting from medical treatment.
4. I hereby authorize the Toledo Bend Family Medicine Clinic to furnish to any facility to which I am transferred any information as may be deemed necessary by the clinic. I hereby release the clinic from all legal liability or responsibility that may arise from the release of such records.
5. I hereby authorize payment directly to the physician of any insurance benefits otherwise payable to me for the period of treatment. I understand that I am financially responsible to the clinic for charges not covered by this authorization.
6. I have been advised of the required privacy regarding my medical records as mandated by the HIPAA regulations. A complete copy of the policy has been made available to me. Because of the privacy regulations we must have your approval to discuss your medical condition with members of your family.

Patient Name: _____ **Patient Signature**: _____

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Please indicate two family members with who we may discuss your medical information:

Name: _____Relationship: _____

Phone: _____ Address: _____

Name: _____Relationship: _____

Phone: _____ Address: _____

Date: _____ **Patient Signature**: _____

Printed Name: _____

Witness: _____ **Relationship to Patient**: _____

If patient is unable to sign, complete the following:
Reason patient is unable to sign _____

Witness _____ Witness _____

Advanced Directive / DNR Information Request

Do you have an Advanced Directive for Medical Care? Yes No
Have you Completed a Do Not Resuscitate Form? Yes No
Do you have a Medical Power of Attorney? Yes No
Would you like to have more information regarding any of the above?
Yes No

Name _____ Date _____