FAMILY FOCUSED CARE
HEALTH FUSION OF TEXAS

Patient Name_____DOB _____

Marital Status: S M W D Sex: M F SS#_____

Address_____City:_____State:_____Zip:_____

Cell Phone#_____ Home Phone# _____ Work Phone# _____

Email Address: _____

Ethnicity:_____ Language: _____

Employer Name & Address: _____

Preferred Pharmacy: _____

Emergency Contact:_____DOB:_____Phone #: _____

Release of Information: Please specify persons that confidential medical information may be released to for the above-named patient. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent. Under the requirements of HIPAA, we are not allowed to give this information without patient's consent.

Name:_____Relationship:_____Phone#: _____

Name:_____Relationship:_____Phone#: _____

ONLY complete if under the age of 18:
Person Responsible for Account:_____DOB:_____
Relation to Patient:_____Phone#: _____

Primary Insurance:_____Phone # _____

ID #:_____Group #: _____

Insured Name: _____ DOB: _____ Relation: _____

Employer:_____Phone #: _____

Consent to Treatment: I authorize and direct Family Focused Care/Health Fusion of Texas to perform treatment upon me. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the treatment. I have read the above statements and hereby consent to the treatment for myself or the minor named above.
Assignment of Benefits: I authorize Family Focused Care/Health Fusion of Texas to treat the above-named patient and to release any medical records required by the insurance company in order to process claims and necessary to secure payment. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. If a telemedicine is performed, I understand that this is a regular office visit and acknowledge I will be charged a $30 copay and will be billed as an office visit the same as I would in the office.

Acknowledgment of Privacy/Office Policies: I acknowledge that I have seen a copy of the Privacy and Office Policies for Family Focused Care. If I would like a copy for myself, I can ask the front desk.

_____ _____ _____
Signature Relation to Patient Date