NORTH TARRANT FAMILY PRACTICE ASSOCIATES

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PATIENT INFORMATION

Patient Name:_____ Sex: M F
Last First MI

Address _____ Apt #_____ City_____ ST_____ Zip_____

Mailing Add_____ City_____ ST_____ Zip_____

Birth Date_____ Age_____ SS#_____-_____-_____ Marital Status S M D W

( )____-_____ ( )____-_____ ( )____-_____
Home Phone Work Phone Cell Phone

Employment Status: Full-time / Part-time / Not Employed / Self / Retired / Active Duty Employers Name _____
(circle all that apply)

Student Status: Full-time / Part-time / Not a student (circle one) **Driver license number**_____

Home e-mail address_____ **May we contact you via e-mail on behalf of NTFP or North Tarrant Skin Care? Yes No**

Emergency Contact Name_____ Relationship to Patient_____ Phone_____

RESPONSIBLE PARTY'S NAME AND ADDRESS (IF DIFFERENT FROM ABOVE)

Name_____ Address_____ Relationship_____

City_____ State_____ Zip_____ SSN_____ DOB_____

PRIMARY INSURANCE INFORMATION

Primary Insurance_____ Policy Holder Name_____

Policyholder's Sex_____ Policyholder's DOB_____ Policyholder's SSN_____

Patient's Relationship to Policyholder_____ Policy Effective Date_____

Policyholder's Employer_____ Member ID#_____

Group #_____ Policy Type: Is this insurance coverage obtained thru an employer? Yes or No (circle one)

SECONDARY INSURANCE INFORMATION

Secondary Insurance_____ Policyholder_____

Policyholder's Sex_____ Policyholder's DOB _____ Policyholder's SSN_____

Patient's Relationship to Policyholder_____ Policy Effective Date_____

Policyholder's Employer _____ Member ID#_____

Group#_____ Policy Type: Is this insurance coverage obtained thru an employer? Yes or No (circle one)

AUTHORIZATION FOR PAYMENT AND RELEASE OF INFORMATION

I HEREBY AUTHOIZE PAYMENT TO NORTH TARRANT FAMILY PRACTICE OF ANY MEDICAL BENEFITS. I AUTHORIZE NORTH TARRANT FAMILY PRACTICE TO RELEASE MEDICAL RECORDS, INCLUDING HIV TESTING AND/OR DRUG/ALCOHOL USE AND TESTING, AS REQUESTED BY REPRESENTATIVES OF INSURANCE COMPANIES OR OTHER RELATED ORGANIZATIONS FOR PAYMENT OF CLAIMS, COMMUNICATION DEVICES MAY BE INTERCEPTED OR INADVERTENTLY TRANSMITTED TO PEOPLE NOT AUTHORIZED TO RECEIVE THE NFORMATION, I HEREBY AUTHORIZE THE TRANSMISSION OF MY MEDICAL RECORD, OR ANY PART THEREOF, ELECTRONICALLY AND THRU FACSMILE (FAX) COMMUNICATION DEVICES. ADDITIONALLY, I UNDERSTAND THAT SOME PROCEDURES/SERVICES PERFORMED BY THE PHYSICIAN(S) MAY NOT BE COVERED BY MY INSURANCE PLAN. IF SERVICES ARE NOT COVERED, I UNDERSTAND AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYMENT FOR SUCH SERVICES.

OFFICE VISIT POLICY: UNLESS OTHER ARRANGEMENTS ARE MADE, ALL OFFICE SERVICES MUST BE PAID AT THE TIME OF SERVICE. WE REQUEST 24 HOURS NOTICE FOR CANCELLATION OF AN APPOINTMENT. WE RESERVE THE RIGHT TO CHARGE **$25.00** FOR FAILURE TO NOTIFY US OF A CANCELLATION. THIS IS A DIRECT CHARGE TO THE RESPONSIBLE PARTY AND IS NOT BILLED TO INSURANCE.

I WILL NOT HOLD NORTH TARRANT FAMILY PRACTICE LIABLE FOR MISSING OR ERRONEOUS INFORMATION CONTAINED ON THIS FORM.

HMO AND PPO POLICY: IF YOU ARE ON AN HMO OR PPO PLAN THAT WE ARE PARTICIPATING IN, WE WILL ACCEPT ASSIGNMENT. HOWEVER, PATIENTS ARE REQUIRED TO PAY ANY DEDUCTIBLE OR CO-PAYMENT THAT MAY BE APPLICABLE. **__**IT IS YOUR RESPONSIBILITY TO VERIFY THAT WE ARE CURRENTLY PARTICIPATING ON YOUR INSURANCE PLAN(S) OR THAT A SPECIFIC SERVICE IS COVERED.__**

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____