Willow Bend Family Medicine, P.A. 6124 W. Parker Rd., Ste. 138 Plano, TX 75093
(972) 981-7000 / Fax: (972) 981-7001

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Cell Phone: _____ Wk Phone: _____ Hm Phone: _____

Address/City/State/Zip: _____

SSN: _____ DOB: _____ Status: **Single / Married / Divorced / Widow / Separated**

Gender Identity: **F / M / FTM / MTF / Decline / Other** Sexual Orientation: **H / Gay / L / Bi / Other / Decline**

Spouse Name: _____ Employer: _____

May we contact you at work? **Y / N** Preferred Method of Contact: **VOICEMAIL / EMAIL / TEXT**

E-mail Address: _____

Emergency Contact Name/Phone: _____ Relationship: _____

PHARMACY PHONE: 1) _____ 2) _____

INSURANCE AND POLICY HOLDER INFORMATION

Insurance: _____ ID#: _____ Group#: _____

Policy Holder's Name: _____ SSN: _____ DOB: _____

Policy Holder's Employer: _____ Relation to Patient: _____ Work #: _____

Policy Holder's address (if different from above): _____

AUTHORIZATION, ACKNOWLEDGEMENT AND CONSENT OF INFORMATION

I hereby consent to the above information and for treatment from Willow Bend Family Medicine physicians, their associates, and /or assistants and accept responsibility for fees for such medical services. I understand that payment (or copay and deductible) is expected at the time of service. I understand that I am financially responsible for charges not paid by my insurance company. If my account is referred to a collection agency I understand a $50.00 fee will be assessed. I hereby authorize my medical benefits to be paid directly to the office of Willow Bend Family Medicine, P.A. and allow the release of medical information necessary to process insurance claims.

NON COVERED MEDICAL SERVICES

I agree and understand that I may have medical services performed by my provider that may NOT be covered under my health plan. I understand and acknowledge that some if not all services provided to me by Willow Bend Family Medicine, P.A. (WBFM) whether at my request or recommendation by my provider may be denied by my health plan and I hereby authorize these services and accept full financially responsibility. Every attempt will be made by Willow Bend Family Medicine, P.A. to collect full reimbursement from my health plan for all medical services provided. This consent expires one (1) year from the date signed. By my signature below, I accept full financial responsibility. I also understand that I may be dismissed from the practice if my financial responsibilities are not honored.

_____ _____

Print Patient Name Signature of Patient or Guardian Date