



Consent to Treat

I hereby authorize employees and agents of Texas Health Physicians Group (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is **only for the date indicated below**. I understand that by not signing this consent, the patient will not be provided medical care.

Treatment Date: _____

Print Patient's Name: _____

Patient Date of Birth: _____

Legal Guardian (if different than patient) _____

Patient or Legal Guardian Signature _____ Date Signed _____

Authorization to Treat a Minor Authorization to Release Medical Information

I give my permission and authorization for the following representative of the school district or organization below (person must be over the age of 18) to obtain medical care for my child. I also authorize the providers of Texas Health Physicians Group to discuss or disclose information regarding any matters relating to my child's appointment and test results or medical care to those listed below. I authorize Texas Health Physicians Group to use the additional contact information listed below to discuss or disclose information regarding any matters relating to this appointment only, test results and/or medical care provided to the school district or the organization and its representative.

School District / Organization _____

Name: _____

Representative's Role in Organization : _____ Phone: _____

PRIVACY PRACTICES

THPG offices, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

THPG PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

DATE: _____

Legal Name: First _____ MI _____ Last _____ Preferred Name: _____

Parent/Legal Guardian Name _____ DOB _____ Mobile _____

SS# _____ DOB: _____ Legal Sex: M F

Do you have any Sexual Orientation or gender preferences you would like us to consider? Yes No

Is your Legal Sex different than your Sex at Birth? Yes No

If you answered yes to either of these questions, additional information will be collected from you later.

Address: _____ Apt # _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-Mail _____ No Email

GENERAL INFORMATION

Marital Status: Divorced Legally Separated Married Significant Other Single Widowed

Need Interpreter Yes No Preferred Language _____ Written Language _____

Race: Asian Black Native American Native Hawaiian/Pacific Islander Two or More Races White

Ethnicity: Hispanic Non-Hispanic

ADDITIONAL DEMOGRAPHICS

Preferred Communication Method: No Preference Mail Phone E-mail My Chart Accept Text Messages

By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from THPG

Do you have any communication difficulties/ special needs? Visually Impaired Yes No Hearing Impaired Yes No Special Needs Yes No

If yes, please list: _____

PCP

Primary Care Physician _____ No Primary Care Physician

EMERGENCY CONTACTS

Name _____ Rel to Patient _____ Home Phone _____ Mobile _____

Name _____ Rel to Patient _____ Home Phone _____ Mobile _____

EMPLOYMENT

Employer Name _____ Employment Status: Disabled Full Time Part Time Retired Student Unemployed