GOODALL-WITCHER
Hospital Authority

Clifton Medical Clinic
201 Posey Ave
Clifton, TX 76634
254-675-8621
254-675-2254 (fax)

PATIENT INFORMATION FORM

In order to serve you more properly, we need the following information. **All information is strictly confidential**. **Please print clearly**.

Patient's Name: ____
Last First MI Maiden

Mailing Address: ____
Street/POB City State Zip

Telephone #: (___)______________________ (___)______________________ (___)______________________
Home Work Cell

Sex: _____ **Birthday**: ______________ **Marital Status**:_____ **TX Drivers Lic #**:____________________

Social Security #: ______________________ ___ **Retired**? __ Yes __No **Employer**: ___________________________

Email Address: ____

Employer's Address: ____ (___)______________________
Street/POB City State Zip Telephone #

Guarantor or Responsible
Party's Name:____
Last First MI

Mailing Address: ____
Street/POB City State Zip

Relationship to Patient: ______________________________ **Social Security** #: ___________________________________

Telephone #: (___)__________________ ___ (___)__________________ ___ (___)__________________________
Home Work Cell

TX Drivers Lic #:_____________________ ___ **Retired**? __ Yes __No **Employer**: _____________________________

Employer's Address: ____ _____ (___)______________________
Street/POB City State Zip Telephone #

Assignment of Benefits

I authorize payment of medical benefits to Clifton Medical Clinic and/or Goodall-Witcher Healthcare Foundation.
This Authorization shall remain valid until revoked, in writing, by patient or guarantor. Please note that Clifton Medical Clinic and Goodall-Witcher Hospital reserves the right not to accept assignment of benefits when such assignment does not conflict with benefit contracts or federal policies.

____ ________________________
Patient or Responsible Party Date

STATEMENT OF PERMIT FOR PAYMENT OF MEDICAL BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENTS

Lifetime Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me be or in Clifton Medical Clinic, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

____ ________________________
Patient/Responsible Party/Subscriber Date

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CONSENT FOR TREATMENT

NAME: ____ **DOB**: __________________________

SEX: _______________ **PHONE NUMBER**: ____

The undersigned hereby makes the following acknowledgements regarding treatment of his/her health related needs:

CONSENT FOR TREATMENT
I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physicians or Nurse Practitioners on duty.
A Nurse Practitioner is NOT a doctor. They are a licensed Registered Nurse who has received advanced education and training in the provision of primary health care. They can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

NO GUARANTEE OF RESULTS
I understand that no guarantee of assurance has been made as to the result s which may be obtained.

AUTHORIZATION FOR RELEASE OF PHYSICIAN/NURSE PRACTITIONER RESPONSIBILITY
If I should leave before completing medical procedures, examinations, or treatment, I hereby release the physician, Nurse Practitioner, and Clifton Medical Clinic from all responsibility for and adverse result.

RELEASE OF MEDICAL RECORDS/INFORMATION
I hereby authorize Clifton Medical Clinic to furnish any medical records to my insurance company or companies, whose policy I am entitled to benefits, for the payment or payments of my medical treatment at the Clifton Medical Clinic.
I hereby authorize Clifton Medical Clinic to furnish any facility, to which I am transferred, any medical information that may be deemed necessary by Clifton Medical Clinic.
I hereby release Clifton Medical Clinic from ALL legal responsibility or liability that may rise from the release of such record or information.

AGREEMENT TO PAY FOR SERVICES RENDERED
I am responsible to Clifton Medical Clinic for ALL charges incurred for services rendered in my health care either through insurance coverage or self-pay.

I have read the above, or have had the information read to me, and fully understand all the information listed.

This is to acknowledge that I understand ALL physician services are provided by contractual arrangements. Physicians are neither employees nor agents of Clifton Medical Clinic or Goodall-Witcher Hospital.

I ____ accept or ____ decline services from the Nurse Practitioners.

____ ___________________________
Patient/Responsible Party **Date**

____ ___________________________
Witness **Date**