Please fill out all the below patient forms **before** coming to your clinic appointment at Cuero Medical Clinic, Parkside Family Clinic, Goliad Family Practice, Kenedy Family Practice or Yorktown Medical Clinic.

Also, please bring the following:

- **Driver's license**
- **Health insurance card(s)**
- **Medicare or Medicaid Card(s)**
- **Current shot record for minors**
- **Current medication list**

Thank you for choosing us for your healthcare needs.

CUERO MEDICAL CLINIC CUEROHEALTH

2500 N. Esplanade, Ste. 102
Cuero, Texas 77954
361-275-3466

PARKSIDE FAMILY CLINIC CUEROHEALTH

1109 E. Broadway
Cuero, Texas 77954
361-275-2800

GOLIAD FAMILY PRACTICE CUEROHEALTH

139 W. Franklin
Goliad, Texas 77963
361-645-8235

KENEDY FAMILY PRACTICE CUEROHEALTH

113 W. Main
Kenedy, Texas 78119
830-583-0612

YORKTOWN MEDICAL CLINIC CUEROHEALTH

508 N. Riedel
Yorktown, Texas 78164
361-564-9230

DeWitt Medical District Clinics
Owned and Operated by Cuero Community Hospital

Patient:_____ **DOB**_____

AUTHORIZATION TO COMMUNICATE WITH FAMILY OR OTHER PARTIES

The purpose of this form is to assist us in carrying out your wishes as to whom we may communicate with when you as a patient are not present.

Please list the parties that you will allow us to communicate information with.

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship_____ Phone_____

Information that you will allow us to discuss with the above listed is:

Medical Information ___All ___Other

Billing Information ___All ___Other

Appointment Information ___All ___Other

The purpose of this Authorization is (Check one or more)

___At the request of the patient/patient's representative

___Other:

If you marked OTHER to any of the above, please see front desk staff.

This authorization is valid for _____. If no date is provided, this authorization is valid for one year.

- You have the right to revoke or change this authorization at any time; such change will only apply to information not already released.
- Should you wish to revoke or change this authorization, you must do so in writing and you must submit to one of the DeWitt Medical District Clinics.
- You understand that you do not have to sign this form in order to receive treatment from Cuero Medical Clinic or Goliad Family Practice.

_____ _____

Patient Signature or Representative Date

Printed Name of Patient or Representative_____

Relationship to Patient_____

DeWitt Medical District Clinics
Owned and Operated by Cuero Community Hospital

PATIENT NAME:_____ **DOB**_____

Patient Agreement

Authorization for Medical Treatment: Office personnel at the DeWitt Medical District Clinics are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

Disclosure of Information: I understand that my medical records and billing information are made and retained by this Practice/Clinic and are accessible to office personnel. Practice/Clinic personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. The Practice/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker' compensation care, or self-insured employer group liable for any part of the Practice/ Clinic Charges and to any health care provider who is or may become involved in my care.

Texas law requires that this Practice/Clinic advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

Financial Responsibility: As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this Practice/Clinic. I understand that payment is expected when services are rendered, unless arrangements have been made in advance.
I understand that it is the patients' or his responsible party's responsibility to provide this Practice/Clinic with the correct insurance to file insurance claim and that that information must be provided in time for the Practice/Clinic to meet filing deadline or I may be responsible for the charges on that service date. I understand that refusal to authorize assignment of insurance benefits will require payment in full by cash or credit card at the time of service.
I understand that x-rays performed at Goliad Family Practice are sent to the radiologist for reading and a separate billing will be sent by them. I also understand that could receive a separate bill from the lab if lab is drawn.

Precertification Policy: I understand that this Practice/Clinic will assist with insurance precertification requirements when the pre-certification involves a diagnosis seen in this Practice/Clinic. This Practice/Clinic will not assume responsibility for precertification or any impact which it may have on insurance payment.

Certification: I hereby certify that I have read each of the above statement, have had the opportunity to have each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____ _____ _____
Patient or Patient's Representative Signature **Relationship to Patient** **Date**

Insurance Benefits and Information Release: I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment form my insurance company and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

_____ _____
Patient's Signature **Date**
(Or parent or guardian's signature if patient is a minor)

DeWitt Medical District Clinics
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PATIENT NAME:_____ **DOB:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 **(HIPAA).** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly

Obtain payment form third party payers

Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read, and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Signature **Date**

_____

Relationship to Patient

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason_____ Date_____

_____ _____

Signature of Clinic Representative Printed Name of Representative

PATIENT NAME:_____ **DOB**_____

Advanced HealthCare Directive

Explanation

A health care directive is useful if you suffered an accident or illness, and could not communicate the type of treatment you wish to receive. Without a health care directive, your health care provider and you family will have to make these decisions without the knowledge of your preferences.

A health care directive is a written document or set of documents that is used to express you healthcare preferences when you are no longer able to personally communicate those wishes. . A health care directive is comprised of 2 parts: a living will and a medical power of attorney

Creating a health care directive DOES NOT require a lawyer, AND it will last until the time of your death.

Living Will

A living will conveys you preferences regarding medical treatment when you are unable. It will contain specific directions for the actions you would or would not like taken if you are in a terminal condition, a permanent coma or in a persistent vegetative state. It can provide instructions about the provision of artificial life support, artificially administered food and water, and comfort or care. **A last will and testament is NOT a substitute for a health care directive. A health care directive deals with your health and personal care and applies when you are alive and cannot communicate your preferences. A last will and testament deals with distribution of property after your death.**

Medical Power of Attorney

A medical power of attorney allows you to designate someone to make health care decision for you when you are unable. He/she will make decisions such as what medical treatments or procedures are necessary. **A durable power of attorney authorizes someone to act for you after you have lost capacity or if you cannot communicate and makes decision about your property and finances and is not the same as a medical power of attorney.**

Health Care Directive

The health care directive is legally binding, once properly signed and witnessed, on family, friends and health care personnel (to the extent your directions are consistent with accepted health care practices). It is important that your health care practitioners, family, friends and your health care representative know where your health care directive can be found.

If your health care provider is unwilling to follow your health care directions, he is obligated to refer you to another health care provider who will honor your instructions.

_____ **I do have an Advance Healthcare Directive**

on file at_____

_____ **I do not have an Advanced Directive**

Signature_____ **Date**_____

Printed Name_____ **Relationship to Patient**_____

DeWitt Medical District Clinics
Owned and Operated by Cuero Community Hospital

Patient Name:_____**DOB**_____

DeWitt Medical District Clinics are participating in a government program to increase the use of digitalized records. The information which you are providing will assist in healthcare outcome research and other observations of health data. This data may be used to drive public health policy or other treatment and disease research.

If you do not wish to provide this information please circle "refused to report."

Thank you for your cooperation.

PLEASE ANSWER ALL THREE QUESTIONS

1. Please circle your Race.
   (Race indicates the genetic group you most closely identify with)

   American Indian or Alaska Native
   Asian
   Black or African American
   Native Hawaiian
   White
   Refused to Report
   Other Pacific Islander
   More than 1 Race

2. Please circle your Ethnicity
   (Ethnicity indicates the cultural group you most closely identify with)

   Hispanic or Latino
   Not Hispanic or Latino
   Refused to Report

3. Please circle the main Language that you use.

   English
   Spanish
   Other_____
   American Sign Language
   Refused to Report