MEDICAL INFORMATION RELEASE

This section authorizes Texas Family Physicians @ River Place to discuss non-sensitive medical information (such as lab test results, appointment verification, etc) with: (please check appropriate box)

Patient Only
Spouse - Specify Name of Spouse:_____
Parent - Specify Parent Name:_____
Other (please specify) _____

TEST RESULTS: ("X" please mark one or all desired)

____ Please leave a message with lab results.
____ Do not leave lab results on the voicemail. I (the patient or parent) will return your call to discuss the results

INITIALS

OFFICE POLICIES

_____ All co-pays are due before your appointment. All other payments are expected at the time of service unless prior arrangements have been made.

_____ A $25.00 fee may be assessed for missed appointments. Please call 24 hours prior to your appointment if you are unable to make it.

_____ We are only using Clinical Pathology Laboratories (CPL) for the labs that are sent out. If your insurance company requires that we use another lab, it is your responsibility to let us know before your appointment.

_____ Please let the receptionist know of any changes in your information (such as insurance, address, phone) before your appointment.

_____ If you need a refill on medication, please call your pharmacy and have them fax us a refill request.

_____ Please allow 48 hours for medication refill requests.

_____ Please allow 5 days for referral requests.

_____ A $25.00 fee may be assessed for medical advice given after hours.

WAIVER OF LIABILITY

_____ **There may be certain services that are not adequately covered by your insurance company. If the provider feels that this service is medically necessary and your insurance company denies payment, it will be your responsibility to pay for that service. This includes all services rendered including but not limited to laboratory service performed in house or sent to an out side lab.**
This section is valid for any date of service from date signed.

_____ _____
Patient Name Printed Date of Birth

_____ _____
Signature of Patient or Responsible Party Date Signed

(Please note you will need to re-sign this form whenever changes are made and/or no later than 1 year from original date signed).

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