Anson General Hospital
ANSON FAMILY WELLNESS CLINIC
215 NORTH AVENUE J ANSON, TEXAS 79501

PATIENT INFORMATION

1. Last Name	2. Middle Name	3. First Name Circle: M F
4. Street Address	5. Mailing Address	6. Education Level
7. City	8. State	9. Zip Code
10. Telephone #	11. Social Security #	
12. Date of Birth	13. Spouse Last Name	14. Spouse First Name Date of Birth: Circle: M F

15. Parent's Name (Child Only)
Father: _____ Father's SSN# _____ Address: _____

Mother: _____ Mother's SSN# _____ Address: _____

16. Employment	17. Supervisor's Name	18. Employer's Telephone
19. Address	20. City & State	21. Zip Code
22. Spouse Employment	23. Supervisor's Name	24. Employer's Telephone
25. Address	26. City & State	27. Zip Code

28. Medicare # **29. Medicaid #**

30. Allergies

31. Person to notify in case of emergency (Not living with you)	32. Relationship	33. Telephone #
34. Address	35. City & State	36. Zip Code

37. PRIMARY INSURANCE COMPANY	**38. SECONDARY INSURANCE COMPANY**
CO.NAME	CO. NAME
ADDRESS	ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
PHONE#	PHONE#
GROUP# (PLAN, LOCAL, OR POLICY #)	GROUP# (PLAN, LOCAL, OR POLICY #)
INSURED'S NAME	INSURED'S NAME
RELATION	RELATION
BIRTHDAY	BIRTHDAY
INSURED'S SSN	INSURED'S SSN
INSURED'S EMPLOYER	INSURED'S EMPLOYER

Signed: _____ Date: _____

Anson Hospital District D/B/A

ANSON FAMILY WELLNESS CLINIC
ASSIGNMENT OF BENEFITS

Name: _____ **Date:** _____

Address: _____ **City/State/Zip:** _____

Insurance: _____

Address: _____

Claim #: _____

SSN/Group#/Certificate #: _____

I hereby instruct and direct the above listed Insurance Company to pay by check any charges for services rendered by Anson Hospital District dba Anson General Hospital and/or Anson Family Wellness Clinic directly to:

Anson Hospital District
101 Avenue J
Anson, Texas 79501
Telephone: 325-823-3231

Should the benefits, under any third party payor plan, whether it be insurance employee benefit plan, an ERISA plan, Local, State, or Federal Agency or program be non-assignable for any reason, I hereby specifically direct that the third party payor send payment to the above address, for any benefits to be paid for care provided to me by **Anson Hospital District** d/b/a **Anson General Hospital**, 101 Avenue J, Anson, Texas 79501, or **Anson Family Wellness Clinic**, 215 North Avenue J, Anson, Texas, 79501. By sending payment in this manner, I release the third-party payor of any liability, under the plan or policy, to the extent of the payments made.

For the professional or medical expense benefits allowable and otherwise payable to me under the current insurance policy as payment toward the total charges for the professional services rendered **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in any current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this ASSIGNMENT shall be considered as effective and valid as the original.

I also authorize release of any information pertinent to a third party should the facility believe it is necessary to process a claim for reimbursement. This assignment will remain in effect until revoked by me in writing.
I authorize the facility listed to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed: _____ Date: _____

Witnessed by: _____ Date: _____

ANSON FAMILY WELLNESS CLINIC

215 North Avenue J Anson, Texas 79501

P:325-823-3209 F:325-823-3600

PRIVATE PAY AGREEMENT

PATIENT NAME:_____

I understand that Anson Family Wellness Clinic is accepting me as a private pay patient and I will be responsible for paying for any services that I receive at the time of service.

I have read the above statement and by my signature below do acknowledge my agreement with its terms.

Signature_____Date:_____
(Patient or Legal Representative)

Witness:_____Date:_____

Anson Hospital District dba

ANSON FAMILY WELLNESS CLINIC

CONSENT TO TREATMENT

Patient's Name: _____ **Date:** _____

I hereby voluntarily consent to the care provided to me by the physicians associated with Anson Family Wellness Clinic encompassing diagnostic procedures, examinations, medical or surgical treatment, or clinical services prescribed by the physicians, physician assistants, and/or advanced nurse practitioners. I further consent to the performance of diagnostic procedures, examinations and rendering of medical treatment by the medical staff their assistants, or their designees as is necessary in the medical staff's judgment.

RELEASE OF INFORMATION: I authorize the Anson Family Wellness Clinic to release medical information to the third-party insurances carriers for the purpose of filing insurance claims related to my medical care. I further authorize the release of medical information about treatment to my doctor or and doctor designated by me.

FINANCIAL AGREEMENT: I agree to be financially responsible and to pay the cost of the services rendered to me to the account of Anson Family Wellness Clinic in accordance with the regular rate and terms of this clinic.

_____ _____ _____

Signature of Patient or Person Authorized to Consent for Patient | Date | Witness

If patient is a minor OR is unable to consent, complete the following:

A. Patient is a minor_____years of age.

   Name of Parent /Legal Guardian: _____

B. Patient is unable to consent because: _____

   _____

   _____ _____

   Signature of Closest Relative or Legal | Witness

In order to control our costs of billing, we request payment of your bill at the time of your office visits. We would rather control our billing costs than be forced to raise our fees. Anson Family Wellness Clinic is owned and operated by Anson General Hospital. Insurance claims and statements will be generated by Anson General Hospital.

ANSON FAMILY WELLNESS CLINIC

PRIVACY NOTICE

Patient's Name: _____Date: _____

I give permission for the staff at Anson General Hospital/Anson Family Wellness Clinic to speak with the following family members regarding my medical condition:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

_____ _____ _____

Signature of Patient or Person Authorized to Consent for Patient | Date | Witness

A. If patient is a minor_____years of age.

Name of Parent/Legal Guardian_____

B. Patient is unable to consent because: _____

_____

_____ _____

Signature of Legal Representative/Guardian/Relationship | Witness

ANSON HOSPITAL DISTRICT

DBA: ANSON GENERAL HOSPITAL & ANSON FAMILY WELLNESS CLINIC

Patient Name: _____

DOB: _____

CONSENT FOR TELECOMMUNICATIONS

In compliance of the Telephone Consumer Protections Act (TCPA), I expressly consent to receive, and authorize **Anson Hospital District**, its affiliate, business associates, and service providers to deliver, or cause to be delivered, calls and SMS/Text and Voice Messages to my cell phone, and residential line as applicable, Using an automatic telephone dialing system and/or using an artificial or pre-recorded voice. This could result in charges to my data plan. These calls and messages will be for health care and other purposed including but not limited to, for the purpose of treatment, appointment reminders and office closure announcements, clinic operations, possible treatment alternatives and other health-related benefits and services that may be of interest, and for the purpose of servicing my account, payment and billing and collecting any amounts I may owe. I have verified that the phone number provided is accurate and I agree to notify **Anson Hospital District** immediately if I change or obtain a new phone number, or no longer maintain the phone number provided herein.

This authorization takes effect immediately and does not have an expiration date. I understand that I may revoke this authorization in writing at any time.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

ANSON FAMILY WELLNESS CLINIC

NEW PATIENT FORM

LAST NAME FIRST NAME MI DOB

REFERRING PROVIDER REASON FOR VISIT

PRESCRIPTION MEDICATION (NAME,STRENGHT,DIRECTIONS)

☐ NO MEDICATIONS

OVER THE COUNTER MEDICATIONS

ALLERGIES

☐ NO KNOWN ALLERGIES

DIAGNOSED MEDICAL CONDITIONS

☐ NO PAST MEDICAL HISTORY

PREVIOUS SURGERIES

☐ NO PRIOR SURGERIES

FAMILY HISTORY OF CONDITIONS

☐ NO FAMILY HISTORY

☐ UNKOWN

SOCIAL HISTORY

IF YES, HOW OFTEN:

DO YOU:

DRINK ALCOHOL ☐ YES ☐ NO

SMOKE CIGARETTES/USE TOBACCO ☐ YES ☐ NO

USE ILLICIT DRUGS ☐ YES ☐ NO