WORLD MEDICAL GROUP PLLC
Primary Care Dba Neuropathy & Pain Center of Texas

PATIENT REGISTRATION

Patient name:_____Birth date (Mo/Day/Yr.) _____

Street address:_____City/State/Zip: _____

Email address: _____ ☐ Web enabled to register for Patient Portal

Social Sec #: _____ *World Medical Group recommends that you provide a private email address to which only you have access.*

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary Ins: _____Policy #:_____Group #:_____

Preferred Pharmacy: _____Address:_____Phone:_____

Preferred method of communication: ☐ Call ☐ Text ☐ Digital ☐ In Person ☐ Mail

Preferred spoken medical language: ☐ English ☐ Spanish ☐ Other:_____

Preferred written medical language: ☐ English ☐ Spanish ☐ Other:_____ Do you require translation (written/verbal) services? ☐ Yes ☐ No ☐ Language: _ _____

Do you ever need help understanding the medical information you receive from your provider/staff? ☐ Yes ☐ No

Race: ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ American Indian or Alaska Native ☐ Prefer not to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Report

Sex: ☐ M ☐ F ☐ Other ☐ Prefer not to report

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated ☐ Single

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EMERGENCY CONTACT/INVOLVEMENT OF OTHERS IN CARE

Name	Date of birth (for Identification)	Relationship to patient	Phone number
			Home:
			Work:
			Cell:

☐ By checking this box, I authorize World Medical Group *to* discuss my/the patient's care and medical needs with the emergency contact above.

☐ By listing below, I authorize World Medical Group *to* discuss my/the patient's care and medical needs with the following persons:

Name	Date of birth (for Identification)	Relationship to patient	Phone number
			HM:
			WK:
			CELL:
			HM:
			WK:
			CELL:

_____Patient/Parent or Legal Guardian Initials

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PATIENT REGISTRATION

Patient name:.....

CONSENT TO TREAT

I voluntarily consent to receive medical and health care services provided by World Medical Group physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatments, I understand that World Medical Group is an affiliated teaching site and may have residents and students involved in my care, I acknowledge that no warranty or guarantee has been made *to* me as *to* result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend or receive services from World Medical Group unless revoked by me in writing with such written notice provided *to* each clinic I attend or from which I receive services.

___**Patient/Parent or Legal Guardian Initials**

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION WITHIN World Medical Group

I understand and agree that: This authorization is voluntary; My Protected Health Information (PHI) may contain information created by others, including health care providers, may include medical, pharmacy, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information1and may include, for example1information relating to visits, admissions, treatment, claims, case management or care coordination; I may not be denied treatment1payment for health care services or enrollment or eligibility for health care benefits if I do not initial this section; The PHI I authorize *to* be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws; I authorize World Medical Group and its affiliates *to* access1use and disclose my individually identifiable PHI between themselves1 and authorize my treating providers (past1present1future) to use and disclose my individually identifiable PHI with World Medical Group and its affiliates. This authorization remains in effect unless and until I revoke it; I may revoke this authorization at any time by notifying World Medical Group in writing. However, the revocation will not have an effect on any actions taken prior *to* the date my revocation is received and processed. I understand that consistent with 42 CFR Part 21I have a right upon my request *to* be provided a list of entities to which my PHI has been disclosed pursuant *to* this general designation, **Patient or Parent/Legal Guardian Initials** ___

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION TO HEALTH INFORMATION EXCHANGES (HIES) AND INTEROPERABILITY EXCHANGES

I understand and agree that: This authorization is voluntary; I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not initial this section; any future HIEs to which World Medical Group connects and their current and future participants may access, use,and disclose my Protected Health Information (PHI) electronically through the exchanges for the purposes of treatment1payment, and health care operations; These entities may conned to other HIEs across the country and I authorize these entities to access use, and disclose my information with those exchanges for the same treatment,payment and health care operation purposes; My PHI, including notes,test results,lab reports,x-rays, medication lists, or any other relevant electronic PHI may be shared through these exchanges; My PHI may be subject to re-disclosure by the recipient entities and if those recipients are not health care providers or health plans, the information may 'no longer be protected by the federal privacy regulations; This authorization remains in effect unless and until I revoke it; I may revoke this authorization at any time by giving written notice to World Medical Group; and I understand that revoking this authorization will not have an effect on any actions taken prior to the date my revocation is received and processed. ___**Patient or Parent/Legal Guardian Initials**

AUTHORIZATION TO RECEIVE PRESCRIPTION HISTORY

I authorize World Medical Group and its Providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand that World Medical Group and its Providers will use my external prescription history to provide me with medical treatment and to evaluate and improve patient safety and the quality of medical care. I understand that I can revoke my permission at any time by giving written notice to my provider,

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Patient name:_____

CONSENT FOR DIGITAL COMMUNICATIONS

By providing my telephone number to World Medical Group, I agree to receive automated calls, prerecorded messages, and/or voice or text messages related to my health care from World Medical Group and its affiliates. I agree to receive text message appointment reminders and clinic-related notifications, such as flu shot availability or closures, on the phone number, I understand that message and data rates may apply, terms arid privacy information are available at the Hulen or Arlington office, and that messages will be recurring, I also acknowledge and agree that these text messages *may* contain Protected Health Information (PHI). Text messaging is not a secure method of communication and carries some risk of being read by a third party. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing.

___**Patient or Parent/Legal Guardian Initials**

CONSENT FOR PHOTOGRAPHY AND VIDEO/AUDIO RECORDING

I consent to World Medical Group taking my image for use in treatment, payment or for health care operations. I understand that my image, including photographs and audio/video recording, will be for the purpose of assisting 1n my care, payment or health care operations including quality initiatives. I understand that World Medical Group will own these images. Copies of them may be available at a reasonable cost. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing, Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

___**Patient or Parent/Legal Guardian Initials**

ASSIGNMENT OF BENEFITS

I authorize World Medical Group to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to World Medical Group, I certify that the information I have reported with regard *to* my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group *to* apply to my account, should a balance exist. This assignment will remain in effect until revoked by me in writing.

___**Patient or Parent/Legal Guardian Initials**

NOTICE OF PAYMENT POLICY

I have received and agree *to* abide by the Payment Policy. A copy will be provided upon request.

___ **Patient or Parent/Legal Guardian Initials**

NOTICE OF TELEHEALTH/TELEMEDICINE SERVICES

I have received notice of my rights with respect to telehealth/telemedicine. A copy will be provided upon request.

___**Patient or Parent/Legal Guardian Initials**

NOTICE OF PRIVACY PRACTICE

World Medical Group Privacy Practice is available to review in the clinic and at Hulen or Arlington office. A copy will be provided upon request I acknowledge receipt of the Notice of Privacy Practice.

___**Patient or Parent/Legal Guardian Initials**

_____ _____

Signature of Patient or Parent/Legal Guardian Date

Please note: If you are a legal guardian or court appointed representative, you must attach a copy of your legal authorization to represent the patient.

Legal Guardian's Name	Street Address/City/State/Zip	Phone number