Patient Information & Acknowledgement
For 18 years & older

Patient First Name: _____ Patient Date of Birth: _____

Patient Last Name: _____ Patient phone #: _____

Address: _____ City/State/Zip: _____

Appointment Reminder Preference: (please select ONLY one)

Phone Call: (which ph #) Email: Text Message: (which ph #) _____
(if you do not confirm your appointment via this method then we will call)

******We need you to provide us with a copy of your Driver's License & Insurance card today. ******

Please initial below as you read.

_____I have carefully read the office and financial policies of Clinical Pediatric Associates of North Texas (CPANT), understand and agree to the terms and conditions as stated.

_____I have received a copy of the office and financial policies of CPANT.

_____I have received a copy of the Privacy Practices.

_____I understand that CPANT reserves the right to modify the privacy practices outlined in the notice.

_____I understand that I can request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

_____ _____
Patient Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

I authorize CPANT to release any of my medical information to:

_____ Insurance company(s) as needed to process any claims, to pay CPANT directly for covered medical and/or surgical services.

_____ The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for CPANT to share my protected health information with:

_____ _____
Name Relationship Name Relationship

_____ _____
Name Relationship Name Relationship

_____ _____
Patient Signature **Date**