**Lawndale Medical Clinic**
**5392900-6**

Date / Fecha: _____

Patient Name
Nomber de paciente : _____

Patient date of birth
Fecha de nacimiento: _____

Patient Address
Direccion: _____

_____

Patient Social Security/ seguro social: _____

Phone / Telefono _____

Patient Pharmacy
Farmacia del Paciente _____

Name of insured
Nombre del dueno de aseguranza: _____

Date of birth of insured
Fecha de nacimiento del asegurado:_____

Staff use only:
Medicaid PCP:_____

Verified by: _____

I, as the patient or legal guardian of the patient, verified the information given here is correct and complete. I understand that cancellations and refunds must be approved in writing by the clinic manager.

Yo, como paciente o guardia legal del paciente, verifico quela informacion escrita aqui es correcta y completa. Yo entiendo que reembolsos y cancelaciones de pago requieren ser aprovadas por escrito por el manager.

Signature
Firma: _____

**Staff use only**
**Provider:**_____

**DX:**_____
**Test:** _____

LAWNDALE Healthcare Management L.L.C.

7109-B LAWNDALE

HOUSTON, TX 77023

PH: 713-924-4907, FX: 713-924-3012

# PATIENT CONSENT TO TREAT AND PROCEDURE

I hereby give my consent to Lawndale Medical Clinic Including (Physicians, Physician Assistants, Nurse Practicioners, and all other staff) and authorize them to provide my medical treatment and procedure. I understand that a physician assistant/nurse practitioner is not a doctor. I also understand that a physician assistant/nurse practitioner is a graduate of a certified training program and is licensed by the State board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat and monitor acute and chronic diseases, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. I understand that at any time I can refuse to see the physician assistant/nurse practitioner and request to see a physician I understand that Lawndale Medical Clinic will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment and / or procedure is provided. I authorize Lawndale Medical Clinic to perform any additional or different treatment and or procedure that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat and procedure form and will have the opportunity to discuss my condition and the procedure(s) with the care provider. All my questions will be adequately answered.

Patient Name _____

Patient Signature _____ Date _____

Parent or Legal Guardian Signature (for minor) _____

Relationship to the Patient _____

Por medio de esta forma, Yo doy mi consentimiento y autorizacion a Lawndale Medical Clinic (incluyendo Medicos, Associado Medicos, y Enfermeras De Practica Avanzada, y cualquer ortro empleado medico) de proveer mi tratamiento y procedimiento medico. Yo entiendo que un Associado Medico/Enfermera de Practica Avanzada no son un Doctor. Tambien Yo entiendo que ellos son graduados de un programa de entrenamiento certificado y que esta bajo licencia del Estado de Texas.

Bajo la supervision de un Doctor un Assistente Medico/Enfermera de Practica Avanzada puede diagnosticar, tratar y monitoriar una condicion medica aguda y tambien proveer un servicio de manteniemiento medico. Supervisar no requiere la presencia fisica del Doctor. Yo entiendo que en cualquier momento puedo negar el servivio del Assitente Medico/Enfermera de Practica Avanzada y pedir mirar a un Doctor.Yo entiendo que Lawndale Medical Clinic me explicara mi condicion(es) medica, riesgos previsibles, y metodos para tratar mi condicion antes de recibir el tratamiento o procedimiento. Yo autorizo a Lawndale Medical Clinic de realizar cualquier otro tratamiento o procedimiento adicional si es necesario en caso de alguna situacion de emergencia que se descubriera una condicion medica que no se conocia anteriormente.

Yo cuidadosamente lei y entiendo completamente esta forma de Consentimiento de Tratamiento y Procedimiento. Yo tendre la oportunidad de hablar con mi proveedor medico sobre mi condicion(es)medica y procedimientos necesarios. Todas mis preguntas seran adecuadamente respondidas.

Nombre del Paciente _____

Firma del Paciente _____ Fecha _____

Firma del Padre/Madre o Guardian Legal (menor de edad)

_____

Relacion con el Paciente_____

LAWNDALE MEDICAL CLINIC
7109- B LAWNDALE
HOUSTON TX 77023
PH: 713-924-4907 FX: 713-924-3012

**Patient consent for H.I.P.PA. Disclosure to friend or family member**

I, _____ give consent to Lawndale Medical Clinic staff to Discuss my medical conditions with _____. These discussions may occur in person or via telephone.

The relationship of this person to me is _____.

Date: _____

_____
Patient printed name

_____
Patient Signature

**Forma de consentimiento de H.I.P.P.A. para un amigo o familiar**

Yo, _____ doy mi autorizacion para que _____ hable con los empleados de la clinic Lawndale Medical Clinic sober mis condiciones medicas. Esta informacion pudiera ocurrir en persona o por telefono.

La relacion de esta persona conmigo es _____
Fecha: _____

_____
Nombre del paciente

_____
Firma del paciente

# Lawndale Medical Clinic Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting **Lawndale MedicalClinic** at **713-924-4907**.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

| | |
|---|---|
| Patient/Parent/Guardian Printed Name | Patient/Parent/Guardian Signature |
| Witness Signature | Date |

**Lawndale Healthcare Management L.L.C.**
7109B Lawndale
Houston TX. 77023
713-924-4907 FX: 713-924-3012

## Acknowledgement of review of notice of Privacy Practices

I have reviewed this office Notice of Private Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Patient's Legal Guardian

Date _____

Yo he revisado la notification de Practica Privada, la cual explica como mi information medica sera utilizada y revelada. Yo entiendo que tengo derecho de recibir una copia de este documento.

_____
Fima del Paciente o Guardian Legal del Paciente

Date _____