Farwell Family Healthcare

405 Ave A S, Farwell, TX 79325 • (806) 481-7000

Patient Name: _____ Date of Birth: _____

Phone: _____ Date: _____

Patient Address: _____ Apt/Unit: _____

City: _____ State: _____ ZIP: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Emergency Phone: _____

Relationship: _____ Emergency Alt Phone: _____

GENERAL CONSENT, FINANCIAL AGREEMENT & PRIVACY ACKNOWLEDGMENT

Consent to Care

I consent to evaluation, treatment, labs, medications, minor procedures, referrals, and other appropriate services by Farwell Family Healthcare. Care may be provided by a nurse practitioner, physician assistant, physician, or other qualified team member.

Not an Emergency Department

Farwell Family Healthcare is not an emergency department. If I need emergency care, hospital-level monitoring, advanced imaging, or services not available here, I may be referred or transferred.

AI Scribe Consent

I agree that an AI-assisted documentation tool may be used to help create visit notes. My provider remains responsible for reviewing and signing the record. I may decline AI scribe use for this visit.

☐ Consent ☐ Decline

Labs, Medications, and Procedures

Visit pricing may not include labs, rapid tests, outside lab fees, medications, injections, supplies, or procedures. These may be billed separately or collected at the time of service.

Financial Responsibility

I authorize Farwell Family Healthcare to bill my insurance and accept assignment of benefits. I am responsible for all amounts not paid by insurance, including copays, deductibles, coinsurance, noncovered services, and self-pay balances.

Self-Pay / Uninsured Notice

If I am uninsured or choose not to use insurance, I may request a Good Faith Estimate when applicable. Same-day walk-in charges depend on the services actually provided.

Privacy Acknowledgment

I acknowledge that I was offered or provided Farwell Family Healthcare's Notice of Privacy Practices. My information may be used and disclosed as allowed for treatment, payment, and healthcare operations.

Communication Consent

I authorize contact by phone, voicemail, text, email, patient portal, or mail regarding appointments, treatment, test results, and billing. I understand text and email may not be fully secure.

Work Comp / Auto Claims

Farwell Family Healthcare cannot see patients for workers compensation claims or motor vehicle accident claims.

Refills / Scheduling

Routine refills should be requested through the pharmacy or patient portal and may take 24-48 business hours. Scheduled visits should be canceled at least 24 hours in advance or a $25 fee may apply.

If I sign for a minor, dependent, or another patient, I certify that I have authority to consent to care and accept financial responsibility as applicable. By signing below, I confirm that I have read this form, had an opportunity to ask questions, and agree to the terms above.

Patient / Parent / Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Release of Information

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OPTIONAL AUTHORIZATION TO DISCUSS CARE WITH OTHERS

Complete this section only if you want Farwell Family Healthcare to discuss appointments, billing, medical information, test results, or treatment plans with another person. This authorization stays in effect until revoked in writing, unless an expiration date is listed below.

Name	Relationship	Phone Number	Information Allowed
			☐ Appts ☐ Billing ☐ Medical ☐ Results
			☐ Appts ☐ Billing ☐ Medical ☐ Results

Expiration date (if any): _____

I understand I may revoke this authorization in writing at any time, except t
action has already been taken based on this authorization.

Patient / Parent / Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____