T & R Clinic, P.A. Patient Policy

Thank you for choosing T & R Clinic, P.A. We are honored to provide quality health care to you and your family

New Patients - New patients are asked to arrive 30 minutes before their appointment time to complete a new patient packet and to allow time for verification of benefits. New patients that arrive less than 15 minutes before their appointment time will be asked to reschedule.

Please arrive 15 minutes before your scheduled appointment time. - T & R Clinic, P.A. requests all patients arrive 15 minutes prior to their scheduled appointment to allow for completion and handling of updates, insurance verification, and other documentation.

Grace Period- T & R Clinic, P.A. allows a 10-minute grace period. After the 10-minute grace period patients may be asked to reschedule.

Late Patients- Late patients may be seen if the providers schedule allows, however, it is likely late patients will need to reschedule. If the providers schedule allows for the late patient to be seen, they will be seen after the last appointment of the morning or afternoon. Late patients will experience extended wait times.

Cancellations and No Shows- It is the patient's responsibility to cancel a minimum of 24 hours before their appointment time. If a patient fails to cancel their appointment 24 hours before their appointment time, or if a patient no shows to an appointment, they may incur a no show or non-cancellation fee of $25.00.

No Shows, Cancellations, and Rescheduled Appointments- Patients with excessive no shows, cancellations, and/or rescheduled appointments may be dismissed from the practice. Patients with excessive no shows, cancellations, and/or rescheduled appointments will not be worked in for non-emergent and non-acute visits.

Reminder Calls- Reminder calls for appointments are a courtesy service and should not be depended upon. If you do not receive a reminder call and fail to attend your appointment, you will be charged a $25.00 no show fee.

Payment – All co-pays, deductibles, and co insurances will be collected before the patient is called back to see their provider. T & R Clinic, P.A strives to make quality care as accessible as possible. To assist with payment issues T & R Clinic, P.A. offers a payment plan. Please ask to speak with a billing representative to see if you qualify.
Self-pay patients and patients on deductible plans are asked for $100.00 deposit at check in. If a patient's visit total exceeds the $100.00 deposit collected, additional payment will be requested. If the visit total is under $100.00, the difference will be returned to the patient.
Patients will be charged a $35.00 fee for returned checks.
T & R Clinic, P.A. will bill your insurance carrier on your behalf. You are ultimately responsible for payment of your bill, including deductibles, co-payment/co-insurance, and non-covered services as determined by your insurance carrier. Any remaining balance owed by you, after insurance has paid, is due in full when you receive your first statement. Balances not paid within 30 days may be subject to additional collection fees.

Insurance Card and Identification- Please bring your insurance card and identification to each visit.

Patients are required to update their information annually- For mutual protection T & R Clinic, P.A. patient information must be updated annually. It is the patient's responsibility to notify T & R Clinic, P.A. of any changes to their demographic and/or insurance information. T & R Clinic, P.A. is not responsible for any issues or charges that may arise as a result of patients failing to update demographics and/or insurance information.

T & R Clinic, P.A.

Minor Children- Minor children may not be left unattended. In the interest of safety, it is important young children are supervised at all times. Children must remain seated and as quiet as possible in clinic waiting areas and public spaces. Only adults over the age of 18 may accompany a minor. If an adult other than the patient's legal guardian is accompanying a minor, they must be on the patients Authorization to Treat a Minor form and must have a valid form of identification.

No Food or Drink- Except for water, no food or drink is allowed in the clinic. If you have a medical necessity, please inform the front office staff**.**

Devices- Please turn the sound off on phones, toys, and electronic devices. Please put your phone or electronic devise away when speaking to T & R Clinic, P.A. staff and providers.

Wi-Fi- T & R Clinic, P.A. does not offer public access to Wi-fi or power.

Dismissals- Patients and providers may end the patient doctor-patient relationship at any time. If you are dismissed from the practice T & R Clinic, P.A. will offer care for 30-days while you look for a different health care provider. Dismissed patients may not transfer to a different T & R Clinic, P.A. physician. You must seek care outside of T & R Clinic, P.A.

COVID-19- For the protection of our elderly, immunocompromised, and high-risk patients, T & R Clinic, P.A. requires all staff and visitors to wear a face mask or acceptable face covering at all times. Masks and face coverings must provide acceptable coverage and completely cover the mouth and nose. T & R Clinic, P.A. staff will call all patients the day before their scheduled appointment to ask COVID-19 screening questions, and out of an abundance of caution patients and guests are required to fill out a COVID-19 symptom questionnaire at check in. Patients arriving for scheduled appointments who have COVID-19 symptoms will be asked to return to their vehicle to address their symptoms via virtual visit. Appointments of symptomatic patients will be rescheduled at the next available appointment time 5 days after symptoms have resolved.

After Hours Care- T & R Clinic, P.A. offers a 24-hour on call service. If you have an emergent medical concern after hours, call T & R Clinic, P.A at 817-831-0321. Please leave a message with our 24/7 answering service and the on-call provider will return your call. On call providers will not address scheduling, referrals, refills, or lab results. Please have the name, address, and phone number of the 24-hour pharmacy nearest you available when the on-call provider returns your call. If you have a medical emergency, please call 911 or go to the nearest emergency room.

Forms- T & R Clinic, P.A. does not print forms for school, sports, or insurance physicals. Please bring printed forms to your visit.

Immunization Records- Patients 18 and under are required to bring an up-to-date immunization record to each yearly physical. Patients without immunization records will be asked to reschedule.

Medications- Patients must bring ALL medications and supplements to each visit. While we encourage patients to keep an updated list of medication with them at all times, it is important to bring medications in their bottles to each visit.

Referrals- Patients must request referrals 5 days prior to their scheduled specialist appointment date. While many specialists take care of referral on the patient's behalf, it is ultimately the patient's responsibility to ensure the specialist has an active referral on file. If you have a new issue that requires a new referral you must see your primary care physician first.

Patient Non-Discrimination and ADA Policy-The services provided by T & R Clinic, P.A are available to all persons desiring those services regardless of race, color, national origin, religion, age, physical or mental handicap.

Hours of Operation-
Monday – Thursday: 7:30 A.M. – 5:00 P.M. ● Friday – Saturday: 8:00 A.M. – 12:00 P.M. ● Closed on Sundays
Clinic doors will be locked on Saturdays. If you have an appointment, call 817-831-0321 for instructions on how to check in.

For the safety of staff and patients T & R Clinic, P.A. utilizes security cameras. These cameras are capable of recording audio and video. To protect patients' privacy cameras are in public spaces only. Phone calls may be recorded for training purposes.

T & R Clinic, P.A.

T & R Clinic, P.A. Patient Policy

Please check the box that applies:

☐ I am the patient.

☐ I am the patient's parent, legal guardian, or power of attorney. Please print full name below.

____

Legal guardian, parent, or power of attorney. (Please Print)

***Please keep the T & R Clinic, P.A. Patient Policy for your records and return this signature page to the front office staff. Front office staff can help answer any questions regarding the policy. ***

Date: ________________________________

Patient Name: ___________________________

Patient D.O.B.: __________________________

My signature indicates the I have read and understood T & R Clinic, P.A.'s Patient Policy. I have been offered a copy for my records and I have been given the opportunity to ask questions regarding the policy.

____

Signature of Patient, Legal guardian, or power of attorney

T & R Clinic, P.A.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

If your child needs medical or hospital services you, as a parent, must give permission. *It's the law*. What if you cannot be reached to give permission? A child may be treated without parental consent when a physician determines a true emergency exists. A true emergency means the child needs immediate medical care and attempting to obtain parental consent would result in a delay that could increase the risk to the child's life or health.

Sometimes a child may need unexpected care which is not truly an emergency. In such cases, attempting to contact a parent for permission can delay treatment and create unnecessary anxiety for the child. To alleviate treatment delays, make sure your child's caregivers know how to contact you at all times. When it may be difficult to contact you, you can appoint an adult to consent to medical treatment for your child.

This document allows you to appoint relatives, friends, and/or caregivers (anyone over 18 years of age) to consent to medical treatment for your child.

Name of Minor: ____ **D.O.B**: ______________________________________

I/We, parent(s) or legal guardian(s) of the above-named minor child, appoint the adult(s) below to consent to medical treatment of my child.

Name & Relationship to Child	Phone #	Address
1.		
2.		
3.		
4.		

*If parents' divorce, the law presumes that the parents should be "joint managing conservators." This means that they would share decision-making responsibilities about a child. If a court has appointed someone to be managing conservator or guardian, please provide the Front Office Staff with a copy of the signed court order.
*A copy of Texas Family Code, Title 2. Child in relation to the family, Subtitle A. Limitations of minority, Chapter 32. Consent to treatment of child by non-parent or child, Subchapter A. Consent to medical, dental, psychological, and surgical treatment, is available by request and can be viewed at https://statutes.capitol.texas.gov/?link=FA.

1**. Parent/Legal Guardian Name**: ____

Please mark the box that applies:
□ Mother □ Father □ Legal Guardian (Legal Guardians may be asked to present signed court documents.)

Address: ____ **Phone#:** ___________________________________

2. Parent/Legal Guardian Name: ____

Please mark the box that applies:
□ Mother □ Father □ Legal Guardian (Legal Guardians may be asked to present signed court documents.)

Address: ____ **Phone#:** ___________________________________

I hereby certify that all the information provided by me in this authorization (or any other accompanying or required documents) is correct, accurate, and complete to the best of my knowledge.

Signature: ____ **Date**: _______________

Updated: 07/20/2022

Patient Portal Consent Form

The patient portal is a secure web portal that allows you as a patient to access medical records including medications, lab results, and medical history via the internet. It also allows you communicate with our office via secure messaging. You may request refills and request referrals online.

Please read the following policy carefully:

• We are offering the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including e-mail addresses, without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.

• We will make every attempt to return portal messages within 24 to 48 hours. You must call our office at 817-831-0321 if you have an urgent matter to discuss.

Please do NOT use the portal for emergencies.

• We do NOT refill controlled substances over the portal.

• If you are not receiving emails from us, please check your JUNK email folder before contacting us.

• By using this patient portal, you agree to protect your password from any unauthorized individuals.

It is your responsibility to notify us should your password be stolen or needs to be reset. You agree not to hold T & R Clinic, P.A. responsible for any network infractions beyond our control.

To OPT IN, please check the "OPT IN" box, sign below and provide a valid e-mail address.

To OPT OUT, please check the "OPT OUT" box and sign below.

☐ OPT IN ☐ OPT OUT

______________________________ ______________________________
Patient's Name (Print) **E-mail Address**

____
D.O.B.

______________________________ ______________________________
Signature (Parent or Guardian if patient is a Minor) Date

T & R Clinic, P.A.

Privacy Questionnaire

*Please **print** clearly in **black ink***

Patient's Name: ____ Patient's D.O.B: ____________________

Primary HIPAA Contact- I grant T & R Clinic, P.A. permission to discuss my general medical condition and diagnosis with the individual listed below.

Name: ________________________________ Relationship: ______________________________

Address: __________________________________ City/State: ______________ Zip: ___________

Phone #: ______________________________ Alternate Phone#: ____________________________

I grant T & R Clinic, P.A. permission to discuss my general medical condition and diagnosis with the individual(s) listed below in case of **EMERGENCY.**

1.Name: ____ Relationship: ______________________________

Address: __________________________________ City/State: ______________ Zip: ___________

Phone #: ______________________________ Alternate Phone#: ____________________________

2.Name: ____ Relationship: ______________________________

Address: __________________________________ City/State: ______________ Zip: ___________

Phone #: ______________________________ Alternate Phone#: ____________________________

___________ Initial — I hereby acknowledge receipt of T &R Clinic, P.A.'s Privacy Practice and my rights regarding my protected health information.

___________ Initial — I authorize T & R Clinic, P.A. to confirm appointment time(s) and date(s) to my employer or school officials for the purpose of verifying excused absences.
□YES □ NO □ Retired □Unemployed □ Child does not attend school

___________ Initial — Can confidential messages i.e., appointment reminders, be left on your home answering machine or voice mail? Please check the appropriate box. □YES □NO

Guardian/Parent Name: ____

Signature: _____________________________ Date: ______________________

T & R Clinic, P.A.

PATIENT NAME: (Nombre de paciente) **DATE:** (Fecha)

REASON FOR VISIT: (Razon de la Visita)

FAMILY HISTORY Please mark all that apply. **HISTORIA FAMILIAR** Por favor, marque todas las que aplican.	**Father (Padre)**	**Mother (Madre)**	**Father's Parents (Abuelos Paternos)**	**Mother's Parents (Abuelos Maternos)**	**Siblings (Hermanos)**	**Children (Hijos)**	**VACCINE (Vacunas)**	**YEAR OF LAST (Ano de la ultima)**
HIGH BLOOD PRESSURE (PRESION ARTERIAL ALTA)							TETANUS/Td (TETANO)	
EPILEPSY (EPILEPSIA)							INFLUENZA (FLU) (GRIPA)	
CANCER (CANCER)							PNEUMONIA (NEUMONIA)	
ECZEMA/PSORIASIS (ECZEMA/SORIASIS)							HEPATITIS (HEPATITIS)	
HEART ATTACK/STROKE (ATAQUE CARDIACO/DERRAME)								
DIABETES (DIABETES)							**TEST/EXAM (TEST/EXAMENES)**	
ASTHMA (ASMA)							RECTAL/STOOL (RECTAL/MATERIA FECAL)	
HAY FEVER (ALERGIA AL POLEN)							CHOLESTEROL (COLESTEROL)	
OTHER _____________ (OTRO) _____________							EYE EXAM (EXAMEN DE LOS OJOS	
OTHER _____________ (OTRO) _____________							T.B. TEST (TEST DE TUBERCULOSIS)	

HOSPITAL ADMISSIONS (HOSPITALIZACIONES) not including pregnancies (No incluya embarazos)	**YEAR (ANO)**	**ILLNESS OR OPERATION (ENFERMEDAD O OPERACION)**	**YEAR (ANO)**	**ILLNESS OR OPERATION (ENFERMEDAD O OPERACION)**

LIST ALL MEDICATIONS YOU ARE NOW TAKING. INCLUDING THOSE YOU BUY WITHOUT A PRESCRIPTION. **(ENUMERE TODAS LAS MEDICINAS QUE ESTE TOMANDO AHORA.** INCLUYENDO ESAS SIN RECETA MEDICA.)			**ALLERGIES (ALERGIAS)**

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (√) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.
(HISTORIA MEDICA Marque (C) por actuales problemas. Marque (√) y escriba la edad cuando tuvo alguno de los siguientes sintomas o enfermedades.)

□ Decreased hearing (Disminucion de la audicion)
□ Ringing in ear (Ruido en los oidos)
□ Ear infections- frequent (Infeccion de oidos-frecuentes)
□ Dizzy spells (Mareos)
□ Fainting Spells (Desmayos)
□ Failing Vision (Vision deficient) □ Eye pain (Dolor de ojo)
□ Double or blurred vision

□ Loss of appetite- recent (Perdida de Apetito- Reciente)
□ Difficulty/swallowing (Dificultad al Tragar)
□ Heartburn (Agrieras) □ Peptic ulcer (Ulcera Peptica)
□ Persistent nausea/vomiting (Nausea Persistente/Vomito)
□ Abdominal pain-chronic (Dolor de Estomago- Cronico)
□ Gall bladder trouble (Problemas de la Vesicula Biliar)
□ Jaundice/Hepatitis

□ Diabetes (Diabetes)
□ Thyroid disease (Enfermedad de la Tiroides)
□ Seizures (Convulsiones) □ Stroke (Derrame Cerebral)
□ Tremor/hands shaking (Temblor/Temblor incontrolable de las manos)
□ Numbness/tingling sensations (Adormecimiento/Sensaciones de Hormigueo)
□ Headaches- frequent (Dolores de Cabeza-frecuentes)

□ Alcohol _______ oz. per wk (Consume Alcohol ___ Oz. por semana)
□ Smoking ___cig/day (Fuma ___ Cig/Dia)
___ # years (anos)
Year quit _________ (Ano que paro de fumar)
□ Coffee/Tea (Café/Te)
_____ cups per day (Tazas al Dia)
□ Recent hair loss (Reciente perdida de cabello)

(Vision doble o borrosa)

□ Nose bleeds- recurrent (Sangrado Nasal- recurrente)
□ Sinus trouble (Sinusitis)
□ Sore throat- frequent (Dolor de Garganta- frecuente)
□ Hoarseness- prolonged (Ronquera- Prolongada)
□ Hayfever/Allergies (Alergia al polen/Alergias)
□ Pnuemonia/ Pleurisy (Neumonia/Pleuresia)
□ Bronchitis/ Chronic cough (Bronquitis/Tos cronica)
□ Asthma/ Wheezing (Asma/Silbido al Respirar)
□ Shortness of breath (Dificultad al respirar)
  - □ on extertion (Haciendo ejercicio)
  - □ lying flat (Estando acostado)
□ Chest pain (Dolor de Pecho)
□ High Blood Pressure (Presion Arterial Alta)
□ Heart murmur (Soplo en el Corazon)
□ Swollen ankles (Tobillos Hinchados)
□ Irregular pulse (Pulso Irregular)
□ Palpitations (Palpitaciones)
□ Leg Pain- when walking (Dolor de piernas-Cuando Camina)
□ Varicose veins/ Phlebitis (Venas Varicosas/Flebitis)

(Ictericia/ Hepatitis)

□ Diarrhea (Diarrea) □ Constipation (Constipacion)
□ Diverticulosis (Diverticulosis)
□ Chrohn's/ Colitis (Colon Irritable/Colitis)
□ Bloody or tarry stools (Heces Fecales con Sangre o Negras)
□ Hemorrhoids (Hemorroides) □ Hernia (Hernia)
□ Urine infections- frequent (Infeccion Urinaria- frecuente)
□ Blood in urine (Sangre en la Orina)
□ Kidney Stones (Calculos Renales)
□ Urination (Orinar Frecuentemente) □ Painful (Con Dolor)
□ Overnight > than twice (Por la Noche > Mas de dos veces)
□ Loss of Control (Perdida de Control)
□ Decrease in force/flow (Disminucion en la fuerza/Chorro Urinario)
□ Venereal disease (Enfermedad Venerea)
□ Urethral discharge (Secrecion Uretral)
□ Chronic fatigue (Fatiga Cronica)
□ Weight-loss (Perdida de Peso) □ Gain-recent (Aumento Reciente)
□ Anemia (Anemia) □ Bruise easily (Moretones con Facilidad)
□ Cancer (Cancer)

□ Arthritis/Rheumatism (Artritis/Reumatismo)
□ Back pain- recurrent (Dolores de Espalda- Recurrente)
□ Bone Fracture/joint injury (Hueso Roto/Lesion Articular)
□ Gout (Gota) □ Osteoporosis (Osteoporosis)
□ Foot Pain (Dolor de Pie)
□ Cold numb feet (Pies frios y adormecidos)
□ Rashes (Erupciones Cutaneas) □ Hives (Urticaria)
□ Psoriasis (Soriasis) □ Eczema (Eczema)
□ Sleeping/concentration difficulty (Dificultad para dormir/ Concentrarse)
□ Depression (Depresion)
□ Nervousness (Nerviosismo) □ Agitation (Agitacion)
□ Memory loss (Perdida de la Memoria) □ Moodiness (Malhumor)
□ Suicidal thoughts (Pensamientos Suicidas)
□ Phobias (Fobias) □ Mental illness (Enfermedad Mental)
□ Feelings of worthlessness (Sentimientos de Inutilidad)
□ Rheumatic Fever (Fiebres Reumaticas)
□ Chicken Pox (Varicela) □ Polio (Polio)
□ Mumps (Paperas) □ Scarlet Fever (Escarlatina)
□ Measles (Sarampion) □ German Measles (Rubeola)
□ Tuberculosis (Tuberculosis) □ Herpes (Herpes)

FEMALES- Complete
PARA MUJERES- Completar

Menstrual flow (Menstruacion):
□ Reg .□ Irreg. □ Pain/cramps
(Reg.) (Irreg.) (Dolor/Colicos)
__Days of flow (Dias del periodo)
__ Length of cycle (Duracion del Ciclo menstrual)

□ Pain/Bleeding during or after sex (Dolor/Sangrado durante o despues del sexo)

Number of (Numero de):
___ Pregnancies (Embarazos) ___ Abortions (Abortos)
___ Miscarriages (Aborto Involuntario)
___ Live births (Nacidos vivos)

Birth Control Method _______ (Metodo Anticonceptivo)
B.C. pill (name) ___________ (Nombre del Anticonceptivo)
□ Flushing/ Menopause (Sofocos/Menopausia)

Date of last Pap test ________ (Fecha de la ultima citologia)
□ Normal (Normal) □ Abnormal (Anormal)

Date of last Mammogram ____ (Fecha del ultimo Mamograma)
□ Normal (Normal) □ Abnormal (Anormal)

OTHER (OTRO)

ADVANCED DIRECTIVES (DOCUMENTO LEGAL PARA SALUD)
□ YES (SI) □ NO (NO) Date (Fecha) ________________
If yes, copy in patient record (Si es asi, copie en el expediente del paciente)

Hepatitis C risk factor (Factores de riesgo para Hepatitis C)
□ Tattoos (Tatuajes) □ Body Piercing (Aretes)
□ Blood Transfusion prior to 1992 (Transfusion de sangre antes de 1992)
□ Contact with bloody/bodily fluid (Contacto con Sangre/Fluidos corporales)
□ Shared razor/toothbrush (Compartio una afeitadora/Cepillo de Dientes)
□ IVdrug use (1+ times) (Uso de drogas intravenosas) (1 o mas veces)

T & R Clinic, P.A PATIENT INFORMATION SHEET

Please **PRINT** clearly in **BLACK** ink. This document is part of your permanent record.

Patient Information

Full LEGAL Name:	D.O.B.:	Social Security #: - -

Address:	Apt #:	City:	State:	Zip:

Home Phone: □ Preferred ( )	Cell Phone: □ Preferred ( )	Work Phone: □ Preferred ( )
Gender: □ Male □ Female	Marital Status: □ Single □ Married □ Divorced □ Widow	Race/Ethnicity: / Preferred Language:
(If under the age of 18) Mother: Phone: ( )	Father: Phone: ( )	Guardian: Phone: ( )
Employed: □ Full time □ Part time	Student: □ Full time □ Part time	□ Retired □ Unemployed □ Disabled / **Email Address:**
Employer/School Name:	Address City/ State Zip Phone: ( )	

Financially Responsible Party

Is the patient the responsible party or guarantor? □ Yes □ No (If you are over the age of 18 and not in the care of an institution you are the guarantor and are financially responsible for any charges you may incur during your visit.)

Name:	Address:	City/State/Zip:	Relationship to patient:

Occupation:	Employer:	D.O.B.: SS#:
Home Phone: □ Preferred ( )	Cell Phone: □ Preferred ( )	Work Phone: □ Preferred ( )

Insurance

Primary Insurance Company:	Subscriber's SS#: D.O.B.:	Policy #:
Subscriber's Name:	Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other	Group #:
Secondary Insurance Company:	Subscriber's SS#: D.O.B.:	Policy #:
Subscriber's Name:	Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other	Group #:

I understand if the information I provide is incorrect or I fail to notify the office of changes, I am responsible for all charges and non-covered medical services.

Do you have a Living Will? □ **Yes** □ **No**	**Do you have a Power of Attorney for Healthcare?** □ **Yes** □ **No**

No Changes

*** For current T & R Clinic, P.A. patients only. New patients may skip this section and proceed to signature and date. ***

□ **No Changes- I certify the information currently on file is correct and up to date.**
By checking the box above, I confirm there are no changes to my demographic and insurance information. I understand inaccurate demographic and insurance information may affect T & R Clinic, P.A.'s ability to contact patients for emergent and non-emergent reasons and may result in denial of insurance claims. T & R Clinic, P.A is not responsible for any issues caused by inaccurate or outdated demographic and/or insurance information.

Name:	**D.O.B:**

I understand T & R Clinic, PA utilizes an Electronic Medical Records System which allows T & R Clinic, P.A. providers access and retrieve any necessary health information from pharmacies and medical facilities internally and externally.

This facility has on staff Nurse Practitioner(s) and Physician Assistant(s) to assist with the delivery of medical care. A Nurse Practitioner /Physician Assistant is NOT a doctor. A Nurse Practitioner is a Registered Nurse who has received advanced education and training in the provision of health care. A Physician Assistant is (PA) is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician. A Nurse Practitioner/ Physician Assistant can diagnose, treat, and monitor common, acute, and chronic diseases, as well as provide health maintenance care. In addition, the Nurse Practitioner/ Physician Assistant may treat minor lacerations and other injuries. I understand that any time I can refuse to see the Nurse Practitioner or Physician Assistant and ask to see a provider.

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company, in writing, at any time.
I hereby authorize T & R Clinic, PA to apply for benefits on my behalf for covered services ordered or rendered by the provider. I request that payment from my insurance company be made directly to T & R Clinic, PA (or to the party who accepts assignment.)

I am granting T & R Clinic, PA permission to notify me of medication, disease, or clinical research issues and advances.

I have read and fully understand the information above and consent by signing below:

Signature____ **Date:** ___________________________