KELLER FAMILY MEDICAL CENTER
808 Keller Parkway, Keller, TX 76248
(817) 431-2573

BURLESON HEALTH & WELLNESS
312 East Renfro Street, Suite 101, Burleson, TX 76028
(817) 710-8800

PATIENT INFORMATION & CONSENT FORM

1. PATIENT REGISTRATION INFORMATION

Patient Name	Phone
Date of Birth	Email
Address	
Insurance Provider / Policy Number	
Emergency Contact (Name / Phone)	

2. PRACTICE POLICIES ACKNOWLEDGMENT-see complete policies on separate page

- Appointments: Please arrive on time; late arrivals may be rescheduled.
- Cancellations: 24-hour notice required or $45 fee applies.
- Payments: Copays and balances are due at time of service.
- Medication Refills: Allow 48 hours; may be denied if visits or labs are overdue.
- Records: Requests require 10 days to process; fees may apply.
- Consent to use of AI Scribe during office visit
- Communication: Calls after 4:00 PM are returned next business day.

Initial to acknowledge receipt of Practice Policies: _____

3. PHI CONSENT & PRIVACY NOTICE

I consent to the use and disclosure of my protected health information (PHI) for treatment, payment, and health care operations by Keller Family Medical Center and/or Burleson Health & Wellness. I acknowledge I have received or been offered a copy of the Notice of Privacy Practices. See attached form for complete information regarding PHI.

☐ I give permission for the office to leave limited voicemail/text messages regarding appointments or results.

I ALSO consent to leave detailed messages or discuss in person my PHI with the following individuals:

My spouse (name)_____ Phone_____

Other (name)_____ Phone_____ Initial to acknowledge: _____

4. RECORDS RELEASE AUTHORIZATION

I authorize Keller Family Medical Center and/or Burleson Health & Wellness to request my medical records from my previous or referring health care provider. This authorization remains valid until revoked in writing.

Name of Provider _____

Address _____ Phone _____ Initial to acknowledge: _____

5. FINAL ACKNOWLEDGMENT & SIGNATURE

By signing below, I acknowledge that I have reviewed and understand all sections above and the additional documents provided, and I agree to the policies and consents contained within these documents.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____