HOWARD J. LANG, D.O., F.A.A.E.M.
FAMILY MEDICINE
ENVIRONMENTAL MEDICINE
OSTEOPATHIC MEDICINE
789 Lonesome Dove Trail
Hurst, TX 76054

Lang Family Medicine
Rooted. Thriving. Natural Healing.

DEREK H. LANG, D.O., F.A.A.F.P.
FAMILY MEDICINE
INTEGRATIVE MEDICINE
OSTEOPATHIC MEDICINE
(817) 577-0480 PHONE
(817) 581-0167 FAX

WELCOME TO OUR PRACTICE

WE APPRECIATE THAT YOU HAVE SELECTED OUR PRACTICE TO SERVE YOUR MEDICIAL NEEDS. TO HELP US PROVIDE YOU THE BEST MEDICAL CARE, WE ASK THAT YOU PLEASE READ THE FOLLOWING SO YOU WILL BECOME MORE FAMILIAR WITH US.

APPOINTMENTS MAY BE SCHEDULED FROM 8:30 A.M. TO 4:15 P.M., MONDAY THROUGH THURSDAY. THE OFFICE IS CLOSED FOR LUNCH BETWEEN 1:00 P.M. – 2:15 P.M. IF FOR ANY REASON YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CONTACT US WITHIN 24 HOURS TO CANCEL OR RESCHEDULE.

PLEASE FEEL FREE TO CALL OUR OFFICE IF YOU HAVE ANY QUESTIONS REGARDING YOUR CONDITION, MEDICATION, OR TREATMENT. TRAINED MEDICAL PERSONNEL WILL ANSWER YOUR QUESTIONS.

IF YOU NEED A REFILL ON YOUR MEDICATION(S), PLEASE CALL YOUR PHARMACY. IF YOU HAVE NO MORE REFILLS LEFT, THE PHARMACY WILL THEN FAX A REFILL REQUEST TO OUR OFFICE AT WHICH TIME THE NURSE WILL SPEAK WITH THE DOCTOR. YOU WILL EITHER GET AN AUTHORIZED REFILL FAXED BACK TO THE PHARMACY OR THE NURSE WILL CALL YOU IF FURTHER APPOINTMENTS OR COMMUNICATION IS NEEDED.

AFTER OFFICE HOURS, EMERGENCIES OR COMPLICATIONS ARE HANDLED THROUGH OUR ANSWERING SERVICE. THE ANSWERING SERVICE **CANNOT** TAKE REFILL REQUESTS OR ADVISE IN ANY MEDICAL TREATMENT. IF YOU CALL AFTER HOURS, OUR RECORDED MESSAGE WILL PROMPT YOU AS TO HOW TO SPEAK WITH OUR ANSWERING SERVICE. PLEASE TRY AND MAKE ALL NON-EMERGENCY CALLS DURING REGULAR OFFICE HOURS. IF YOU HAVE BEEN REFERRED TO US BY ANOTHER PHYSICIAN, PLEASE LET US KNOW SO WE MAY REPORT TO HIM OR HER PROMPTLY.

**************************VERY IMPORTANT**************************

BECAUSE MANY OF OUR PATIENTS HAVE ALLERGIES AND SENSITIVITIES TO VARIOUS SUBSTANCES, WE ASK THAT YOU PLEASE NOT WEAR ANY PERFUME, COLOGNE, FRAGRANCED BODY OR HAND LOTION, AFTERSHAVE, ETC., TO YOUR APPOINTMENT.

WE ARE NOT PROVIDERS WITH ANY INSURANCE GROUP

PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME TREATMENT IS RENDERED.

FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & HEALTH SAVINGS ACCOUNT CARDS.

IF YOU HAVE MEDICAL INSURANCE THAT YOU WOULD LIKE TO FILE, YOU WILL BE GIVEN A RECEIPT UPON CHECKING OUT THAT WILL ENABLE YOU TO FILE YOUR CLAIM WITH EASE.

PLEASE REMEMBER THAT YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR PAYMENT OF ALL CHARGES AT THE TIME OF SERVICE.

PLEASE DON'T HESITATE TO ASK ANY OF OUR STAFF FURTHER QUESTIONS THAT YOU MAY HAVE. CINDY, OUR OFFICE MANAGER, IS ALSO AVAILABLE TO ASSIST YOU WITH ANY QUESTIONS OR CONCERNS YOU MAY HAVE.

Thank you,

Dr. Howard J. Lang, D.O., F.A.A.E.M.
Dr. Derek H. Lang, D.O., F.A.A.F.P.

I understand that my signature represents that I have read and understand the above policies. I agree to make payment in full at the time of my office visit(s).

_____ _____

PATIENT SIGNATURE **DATE**

INSTRUCTIONS FOR LEAVING MESSAGES AND/OR DISCUSSING YOUR MEDICAL CONDITION WITH OTHERS

SPEAK ONLY TO ME ___YES ___NO _____INITIALS

OK TO SPEAK TO MY SPOUSE ___YES ___NO _____INITIALS

OK TO SPEAK TO MY PARENTS ___YES ___NO _____INITIALS

OK TO LEAVE MESSAGE ON MY ANSWERING MACHINE ___YES ___NO _____INITIALS

OK TO LEAVE MESSAGE ON MY VOICEMAIL ___YES ___NO_____INITIALS

OTHER (specify) _____ ___YES ___NO _____INITIALS
(Such as grandparent, other relative)

_____ _____

DATE **SIGNATURE**

PLEASE LIST THE NAMES OF FAMILY OR FRIENDS THAT MAY PICK UP YOUR ALLERGY VIALS, VITAMINS OR PRESCRIPTIONS:

1) _____ **3) _____**

2) _____ **4) _____**

RELEASE OF MEDICAL RECORDS:

Your insurance company may request additional information so that your claim may be processed. We will need your signature to authorize us to send any additional information they may need to process your claim. If you choose not to sign, your claim may not be able to be processed efficiently, therefore delaying or possibly denying any reimbursement due to you.

_____ _____

Signature Date