

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_

 Please be advised that you will be required to complete this form at your first office visit of each year. The information you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male: \_\_\_\_\_\_ Female: \_\_\_\_\_\_\_

Marital Status: (Circle one) Married Single Divorced Widow Partner Legally Seperated

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Power of Attorney:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance # 1: Insurance #2:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, understand, hereby authorize payment directly to Primary Care Associates of texas for medical services rendered. I understand I am financially responsible for all charges not covered or authroized by my insurance company.

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2017

 

 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply: **Race** \_\_ American Indian \_\_ Asian \_\_ African American \_\_ White \_\_ Hispanic \_\_ Indian **Ethnicity**  \_\_ Hispanic or Latino \_\_\_ Not Hispanic or Latino  **Language**  \_\_English \_\_\_ Spanish \_\_\_ Hearing Impaired \_\_\_\_Other

 **Acknowledgement of Privacy Practices**

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) patients have certain rights to privacy regarding their protected health information. Your protected health information will be used to:

* Conduct, plan, and direct treatment by the physicians employed by Primary Care Associates of Texas will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
* To obtain payment from third party payers.
* To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waved your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Primary Care Associates of Texas has previously released relying on this consent.

**Do we have permission to? Leave a detailed message** regarding any appointments, treatments or test results at any of the following numbers we have on file for you: **Home:** \_\_\_Yes \_\_No **Cell:** \_\_Yes \_\_No **Work:** \_\_Yes \_\_No **Mail detailed information** regarding appointments, treatments or tests results to your home address: \_\_Yes \_\_No **Email detailed information** regarding appointments, treatments or test results to the email address you have provided us with: \_\_Yes \_\_No

 **Please ask for Patient Portal login if not already enrolled.**

**Please list anyone who you give us permission to discuss your medical records with:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Contact Number** |
|  |  |  |
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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2017

 **Authorization to Release Healthcare Information** **Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.** Covered entities as that term is defined by HIPAA and Texas Health & Safety Code 181.001 must obtain a signed authorization from the individual or the individual’s legally authorized representative to electronically disclose that individual’s protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on failure to sign this form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I request and authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release the medical records of the patient named above to: **Primary Care Associates of Texas 6000 Colleyville Blvd, Suite 150 Colleyville, TX 76034 (817) 406-3732**

**What information can be disclosed?** Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, the check only the first box.

**\_\_\_ All health information\_\_**History/Physical\_\_\_Exam \_\_Past/Present Medications\_\_\_Lab results\_\_Physician’s Orders \_\_\_ Patient Allergies\_\_\_Operation Reports\_\_\_Consultation Reports\_\_\_Progress Notes\_\_\_Discharge Summary \_\_\_ Diagnostic Test Reports\_\_\_Billing Information\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your initials are required to release the following information:** \_\_\_\_Mental Health Records (excluding Psychotherapy notes) \_\_\_\_\_ Genetic Information (including Genetic Test Results) \_\_\_\_Drug, Alcohol, or Substance Abuse Records \_\_\_\_HIV/AIDS Test Results/Treatment

 I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus,) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment. **Effective Time Period.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of maturity; or permission is withdrawn’ or the following specific date (optional): Month: \_\_\_ Day: \_\_\_\_ Year:\_\_\_ **Right To Revoke.** I understand that I can withdrawal my permission at any time by giving written notice stating my intention to revoke this authorization to the person or organization name under “WHO CAN RECEIVE AND USE THE HEALTH INFORMATION”. I understand that prior actions taken in reliance on this situation by entities that had permission to access my health information will not be affected. **Signature Authorization**. I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that it is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_ Relationship if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

 2017

 

 

 **Patient Information Questionnaire**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please complete to the best of your knowledge. This will help the doctor during today’s visit. Thank You!

Please circle your answers

 **When was your last visit to your primary care doctor?**

Over a year? More than 6 months Less than 6 months I don’t have one

 **When was your last Colonoscopy?**

Within 5 years More than 5 years Never

**If done, was it normal?** Yes No

 **Have you ever been told you have the following: (Circle all that apply)**

Hepatitis Cirrhosis Osteoporosis Diabetes Family history of Diabetes

Addison’s or Cushing’s syndrome High total cholesterol Kidneys Disease Family History of Kidney

Disease Polycystic Kidney Disease GOUT GERD Fatty Liver

**Have you experienced the following?**

Difficulty swallowing Recurrent kidney stones Unexplained weight loss/ gain

Long term high blood pressure Foam or blood in urine Chest pain or discomfort

Shortness of breath Joint pain or swelling Swollen ankles Dizziness

 **Have you been experiencing any of these symptoms in your legs more than 3 times a week?**

Discoloration of pain Varicose Veins Numbness Tingling Sores

 **Do you take pain medication more than 3 times a week?** YES NO

**If so, do you take any of the following for pain?**

Tylenol Advil Aleve Ibuprofen Prescription Something else

 

 **Medication List**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose** | **Directions** |
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**Physician List**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Physician/Specialist Address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardiologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pulmonologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Endocrinologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Neurologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gastroenterologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hematologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Urologist

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other

 **Phone & Fax Number:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardiologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pulmonologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Endocrinologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Neurologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gastroenterologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hematologist

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Urologist

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other

 

**Patient Medical History Questionnaire**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if you have any of the following conditions below:

**Cardiology:** \_\_\_ Hypertension \_\_\_ Angina \_\_\_ Heart Attack \_\_\_ Heart Failure \_\_\_ Atrial Fibrillation \_\_\_ Irregular Heart Beat \_\_\_ Heart Murmur \_\_\_ Peripheral Vascular Disease \_\_\_ Aortic Aneurysm

**Gastrointestinal:** \_\_\_ Acid Reflux \_\_\_ Ulcer Disease \_\_\_ Gall Bladder Disease \_\_\_ Vomiting Blood \_\_\_ Blood in Stool \_\_\_ GI Cancer \_\_\_ Diverticulosis \_\_\_ Polyps

**Hematology:** \_\_\_ Anemia \_\_\_ Leukemia \_\_\_ Bleeding Disorder \_\_\_ Blood Clots (legs) \_\_\_ Multiple Myeloma \_\_\_ Varicose Veins \_\_\_ HIV**Pulmonary:**  \_\_\_ Asthma \_\_\_ Chronic Bronchitis \_\_\_ Emphysema \_\_\_ COPD \_\_\_ Pneumonia \_\_\_ Pulmonary Hypertension \_\_\_ Clot in the lungs \_\_\_ Sleep Apnea \_\_\_ Lung Cancer

**Liver Disease/Pancreas:**  \_\_\_ Hepatitis (type\_\_\_) \_\_\_ Cirrhosis \_\_\_ Liver Cancer \_\_\_ Gallbladder Stones \_\_\_ Pancreatitis \_\_\_ Pancreatic Cancer

**Neurology:**  \_\_\_ Neuropathy \_\_\_ TIA \_\_\_ Stroke \_\_\_ Migraine \_\_\_ Seizure \_\_\_ Parkinson’s Disease \_\_\_ Alzheimer’s/ Dementia**Endocrine:** \_\_\_ Diabetes Type 1 \_\_\_ Diabetes Type 2 \_\_\_ Thyroid Issues (high/low) \_\_\_ Addison’s Disease \_\_\_ Cushing’s Syndrome \_\_\_ Pituitary Adenoma \_\_\_ High Cholesterol \_\_\_ Obesity

**Genitourinary:**  \_\_\_ Recurrent UTI \_\_\_ Kidney Stones \_\_\_ Chronic Kidney Disease \_\_\_ Nephritis \_\_\_ Prostate Problem \_\_\_ Kidney Cancer \_\_\_ Bladder Cancer

**Arthritis & Musculoskeletal:**  \_\_\_ Rheumatoid Arthritis \_\_\_ Osteoarthritis \_\_\_ Gout \_\_\_ Osteoporosis/Osteopenia \_\_\_ Lupus (SLE) \_\_\_ Scleroderma \_\_\_ Sjogren’s Syndrome \_\_\_ Fibromyalgia

 

**Patient Medical History Questionnaire**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Please make a check in the boxes that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Status:A=Alive D=Deceased Please circle one | High BP | Diabetes | Heart Disease | Kidney Disease | Stroke | Cancer |
| Father | A D |  |  |  |  |  |  |
| Mother | A D |  |  |  |  |  |  |
| Paternal Grandfather | A D |  |  |  |  |  |  |
| Paternal Grandmother | A D |  |  |  |  |  |  |
| Maternal Grandfather | A D |  |  |  |  |  |  |
| Brother(s) | A D |  |  |  |  |  |  |
| Sister(s) | A D |  |  |  |  |  |  |
| Sons(s) | A D |  |  |  |  |  |  |
| Daughter(s) | A D |  |  |  |  |  |  |

**Social History:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current Use | Frequency | If use, When? |
| Smoking |  |  |  |
| Alcohol |  |  |  |
| Illicit Drug Use |  |  |  |

**Please CIRCLE your answer below**:

Married: Y N Living With: Spouse Alone Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu Shot: Y N Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcal Vaccine: Y N Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

**Patient Medical History Questionnaire**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date/Year | Hospital Name | Reason for Hospitalization |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

**Surgeries:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date/Year | Surgeon Name | Nature of Surgery |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

**Procedures:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date/Year | Performed By | Result |
| Upper GI Endoscopy |  |  |  |
| Colonoscopy |  |  |  |
| Biopsy |  |  |  |
| Cardiac Stress Test |  |  |  |
| Pap Smear |  |  |  |
| Mammogram |  |  |  |

 

 **Controlled Substance Medication Agreement**

I, (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that my Physician (hereinafter to refer to as “Physician”) is prescribing a controlled substance medication as part of my treatment plan. This Controlled Substance Medication Agreement (“Agreement”) is a tool for communication allowing us to work together in good faith and for you to understand the importance of this medication. In prescribing a controlled substance medication, we must partner with our patients to create the best treatment plan for your improvement and/or management of pain. This requires cooperation, trust, and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled medication and/ or dismissal from our practice.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my Physician.
2. I will keep regularly scheduled appointments with my Physician. There may be times when your medication will need a refill between office visits. In that occurs, please call our staff at least 5 days before your medications run out. Refill requests will only be taken Monday- Friday from 8 am to 5 pm. Your physician or an on-call physician will not refill any pain medications after hours or on weekends. If you have uncontrolled pain during a weekend, medical care should be sought from an emergency room or immediate care center.
3. The controlled substance medication prescribed is being given in order to control pain and/or improve function. If there are any changes to your activity level of physical condition, the treatment may be changed or discontinue. You are responsible for notifying your Physician of such changes.
4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves. If your condition does not improve, your Physician may recommend additional conservation or invasive neurosurgical procedures. If your level of pain still does not allow you to taper and discontinue the controlled substance pain medication, you will be referred to a pain management specialist for management of your pain medications.
5. I agree to act responsibly, including protecting and limiting access to these medication by keeping them in a safe place, and to dispose of any unused medication in a proper manner.
6. You are not to accept or seek controlled substance medication from any other physician or health care provider outside of our practice while we are prescribing controlled medication. It is essential that only one physician monitor and evaluate your use of pain medication.
7. If you have another condition that requires the prescription of a controlled substance medication, we will coordinate with the original prescribing physician and all prescribed controlled medications will also be coordinated as well.
8. It is required that you use a single pharmacy for all prescriptions (Provide pharmacy information below). You may use a chain of pharmacies with different branches, as the prescription information is available at all branches. This is required to make certain that your medications are known by a pharmacist able to evaluate any concerns about interactions of medication.
9. I understand that, lost, stolen, or misplaced prescriptions or pills WILL NOT BE REPLACED. All patients are required to act responsibly with their medications. This medication is prescribed for you and only your specific needs. To allow others to use your medication is illegal and dangerous. This type of behavior will not be tolerated by your physician or our practice. Proof of a police report will need to be provided should theft be a concern.
10. I agree I will not use any other illegal and/or recreational drug(s) while receiving care and pain medication from this practice. Use of illegal and/or recreational drug(s), especially while also taking pain medication is extremely dangerous and potentially lethal.
11. I recognize altering a prescription in anyway is against the law. Fabricating prescriptions or forging a provider’s signature is also against the law. I realize that if I commit this law violation it will be reported to my pharmacy, local authorities, and the Drug Enforcement Agency (DEA).
12. I agree and understand that my physician reserves the right to obtain random or unannounced prescription drug testing. The drug testing will be required at a minimum of the onset of the prescription and every 3-6 months thereafter depending upon the medications and dosing. If I fail to provide the sample when asked or if the results are inconsistent, I may forfeit the right to continue receiving care.
13. You should inform your physician of all medications you are taking including herbal remedies, since controlled substances can interact with over the counter medications and other prescribed medications, especially cough syrup that contains alcohol, codine or hydrocondone.
14. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulating agency to obtain or provide information about your care or actions, if the physician feels it is necessary.

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOU HAVE ANY QUESTION OR CONCERNING OUR MEDICATION AGREEMENT OR WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF.

I have read this agreement. I fully understand the consequences of violating this agreement may include cessation of treatment, and/ or dismissal from the practice.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

 **PPG HEALTH**

 **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

 **PLEASE REVIEW IT CAREFULLY.**

 EFFECTIVE 10/01/2015

This Notice of Privacy Practices (the "Notice") tells you about the ways we may use and disclose your

protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to PPG Health including its providers and employees (the “Practice").

1. **OUR OBLIGATIONS.**

 We are required by law to:

* Maintain the privacy of your medical information, to the extent required by state and federal law;
* Give you this Notice explaining our legal duties and privacy practices with respect to medical information

 about you;

* Notify affected individuals following a breach of unsecured medical information under federal law; and
* Follow the terms of the version of this Notice that is currently in effect.
1. **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

 The following categories describe the different reasons that we typically use and disclose medical

information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

1. **For Treatment.** We may use and disclose medical information about you to provide you with

health care treatment and related services, including coordinating and managing your health care. We may

disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

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**B. For Payment.** We may use and disclose medical information about you so that we or may bill

and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

**C.** **For Health Care Operations.** We may use and disclose medical information about you for our

health care operations. These uses and disclosures are necessary to operate and manage our practice and to

promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

**D.** **Quality Assurance**. We may need to use or disclose your medical information for our internal

processes to assess and facilitate the provision of quality care to our patients.

**E. Utilization Review**. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

**F. Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

**G. Treatment Alternatives.** We may use and disclose medical information to tell you about or

recommend possible treatment options or alternatives that we believe may be of interest to you.

**H**. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

**I. Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safe guard your information.

**J. Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

**K. As Required by Law**. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

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**L. To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical

information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

**M. Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical

information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

**N. Research.** We may use or disclose your medical information for research purposes in certain

situations. Texas law permits us to disclose your medical information without your written authorization to

qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "unidentified."

**O. Military and Veterans.** If you are a member of the armed forces, we may use and disclose

medical information about you as required by the appropriate military authorities.

**P. Workers' Compensation**. We may disclose medical information about you for your workers'

compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

**Q. Public Health Risks.** We may disclose medical information about you to public health authorities or public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

 \* To prevent or control disease, injury, or disability (including the reporting of a particular disease or

 injury).

 \* To report births and deaths.

 \* To report suspected child abuse or neglect.

 \* To report reactions to medications or problems with medical devices and supplies.

 \* To notify people of recalls of products they may be using.

 \* To notify a person who may have been exposed to a disease or may be at risk for contracting or

 spreading a disease or condition. \* To notify, the appropriate government authority if we believe a patient has been the victim of abuse,

 neglect, or domestic violence. We will only make this disclosure if you agree or when required or

 authorized by law.

\* To provide information about certain medical devices.

\* To assist in public health investigations, surveillance, or interventions.

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**R. Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

**S. Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

**T. Law Enforcement.** National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**U. Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

**V. Inmates**. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

**W. Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (I) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (I) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

**X. Fundraising**. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

**Y. Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

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**III. OTHER USES OF MEDICAL INFORMATION**

**A. Authorizations**. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific c written authorization.

**B. Psychotherapy Notes**. Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

**C. Right to Revoke Authorization**. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

**IV. YOUR ITIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.** Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

**A. Right to Inspect and Copy**. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your -"medical and billing records' To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA officer at the address listed in section VI below. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law. If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the practice and you. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you, are denied access to medical information you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

**B. Right to Amend.** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide areas on as to why you want this amendment. If we accept your request, we will notify you of that in writing. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (I) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment|, (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**C. Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures. If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below. Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically. The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved und you, may choose to withdraw or modify your request at that time before any costs are incurred.

**D. Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such is when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

**E. Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below. We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specific, how and where you wish to be contacted.

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**F. Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below. ‘G’ Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

**G. Right to Breach Notification.**  In certain instances, we may be obligated to notify you ( and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a “breach” as defined in and /or required by HIPAA and applicable state law.

**V**. **CHANGES TO THIS NOTICE.**

 We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. \*h., changes have been made to the Notice, you may obtain a revised copy by sending u letter, to the Practice's HIPAA officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

**VI. COMPLAINTS.**

If you believe that your privacy rights as described in this Notice have been violated, you may complaint with file the Practice at the following address or phone number:

PPG Health Attn: HIPAA Officer 1001 Pennsylvania Ave Fort worth, TX 76104 817-877-5858

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

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VII. **ACKNOWLEDGEMENT AND REOUESTED RESTRICTIONS.**

 By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specific as applicable) of my information:

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please Print Name)

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURES:**

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

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