Tri-MED
INTEGRATIVE PSYCHIATRY & SLEEP MEDICINE
Maximal Health, Minimal Medicine

PATIENT LAST NAME: _____
PATIENT FIRST NAME: _____
DOB: _____ S.S.NUMBER: _____
HEIGHT:_____ WEIGHT:____PHONE NUMBER_____

ADDRESS:_____
EMAIL:_____
PRIMARY INSURANCE:_____ ID#:_____
SECONDARY INSURANCE:_____ ID#:_____
PHARMACY:_____ PHONE#:_____
REFERRAL SOURCE: _____ PHONE#: _____

EMERGENCY CONTACT INFORMATION:

NAME:_____ PHONE#_____ CAN WE LEAVE MESSAGE: **Y N**
RELATIONSHIP TO PATIENT: _____ POWER OF ATTORNEY: **Y N**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION/ MEDICAL RELEASE:

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE:_____ FAX:_____
ONLY RELEASE HEALTH INFORMATION ONLY RELEASE BILLING INFORMATION
RELEASE ALL INFORMATION TO THE ABOVE MENTIONED ONLY RELEASE:_____

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE#_____ FAX:_____
ONLY RELEASE HEALTH INFORMATION ONLY RELEASE BILLING INFORMATION
RELEASE ALL INFORMATION TO THE ABOVE MENTIONED ONLY RELEASE:_____

Please list current or past medications, doses, and frequency taken:

MEDICATION	DOSE (MG.)	FREQUENCY	PAST / PRESENT
1			
2			
3			
4			
5			
6			

Do you have any **Drug allergies?** If yes, please list the drug and reaction: _____
_____
Have you had any seizures in the past? If yes, list the date: _____
Have you experienced a poor response / intolerable side effects to antidepressants in the past?_____
Have you participated in: Inpatient Psychiatric Hospital or Intensive Outpatient Program?_____
Are you currently pregnant, breastfeeding or planning to become pregnant in the next 6 months?_____

Have you ever been diagnosed or treated for the following?

- ❑ ADHD/ADD
- ❑ Intellectual Disabilities
- ❑ Sedative Dependence
- ❑ Panic Disorder & Agoraphobia
- ❑ Major Depressive Disorder
- ❑ Pseudobulbar Affect (PBA)
- ❑ Alcohol Dependence
- ❑ Nicotine Dependency
- ❑ Substance Abuse
- ❑ Anorexia
- ❑ Insomnia
- ❑ Borderline Personality Disorder
- ❑ Social Anxiety/Social Phobia
- ❑ PTSD
- ❑ OCD
- ❑ Chronic fatigue
- ❑ Paranoid Schizophrenia
- ❑ Cannabis Dependence
- ❑ Delusional Disorder
- ❑ Schizoaffective Disorder
- ❑ Bipolar and/or Mood Disorder
- ❑ Generalized Anxiety Disorder

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____
PATIENT SIGNATURE **DATE**

Have you used any of the following substances in the last 6 months? If yes, please list how often you have used them, the last date of use and if prescribed.

Marijuana: ☐No ☐Yes Frequency: _____ Last Used:_____ Prescribed?☐No ☐Yes
Opiates: ☐No ☐Yes Frequency: _____ Last Used:_____ Prescribed?☐No ☐Yes
Ketamine: ☐No ☐Yes Frequency: _____ Last Used:_____ Prescribed?☐No ☐Yes
Cocaine: ☐No ☐Yes Frequency: _____ Last Used:_____
Alcohol: ☐No ☐Yes Frequency: _____ Last Used:_____
Tobacco: ☐No ☐Yes Frequency: _____ Last Used:_____
Vape: ☐No ☐Yes Frequency: _____ Last Used:_____
Phencyclidine (PCP): ☐No ☐Yes Frequency: _____ Last Used:_____
Lysergic Acid Diethylamide (LSD): ☐No ☐Yes Frequency: _____ Last Used:_____
Psilocybin (magic mushrooms): ☐No ☐Yes Frequency: _____ Last Used:_____

MEDICAL HISTORY

Do you now, or have you ever had:

- ❑ Diabetes
- ❑ Obstructive Sleep Apnea
- ❑ Crohn's disease
- ❑ High blood pressure
- ❑ Pneumonia
- ❑ Colitis
- ❑ High cholesterol
- ❑ Pulmonary embolism
- ❑ Anemia
- ❑ Hypothyroidism
- ❑ Asthma
- ❑ Jaundice
- ❑ Hyperthyroidism
- ❑ Emphysema
- ❑ Hepatitis
- ❑ Cancer (type)_____
- ❑ Stroke
- ❑ Stomach or peptic ulcer
- ❑ Leukemia
- ❑ Epilepsy (seizures)
- ❑ Rheumatic fever
- ❑ Psoriasis
- ❑ Food Allergies
- ❑ Tuberculosis
- ❑ Angina
- ❑ Kidney disease
- ❑ HIV/AIDS
- ❑ Heart problems
- ❑ Kidney stone

SYSTEMS REVIEW	In the past month, have you had any of the following problems?	
GENERAL	**THROAT**	**SKIN**
❑ Recent weight gain; how much	❑ Frequent sore throats	❑ Redness
❑ Recent weight loss: how much	❑ Hoarseness	❑ Rash
❑ Fatigue	❑ Difficulty in swallowing	❑ Nodules/bumps
❑ Weakness	❑ Pain in jaw	❑ Hair loss
❑ Fever	**NERVOUS SYSTEM**	❑ Color changes of hands or feet
❑ Night sweats	❑ Headaches	**BLOOD**
MUSCLE/JOINTS/BONES	❑ Dizziness	❑ Anemia
❑ Numbness	❑ Fainting or loss of consciousness	❑ Clots
❑ Joint pain	❑ Numbness or tingling	
❑ Muscle weakness	❑ Memory loss	**PSYCHIATRIC**
❑ Joint swelling	**STOMACH AND INTESTINES**	❑ Depression
Where?	❑ Nausea	❑ Excessive worries
EARS	❑ Heartburn	❑ Difficulty falling/staying asleep
❑ Ringing in ears	❑ Stomach pain	❑ Poor appetite
❑ Loss of hearing	❑ Vomiting	❑ Frequent crying
EYES	❑ Yellow jaundice	❑ Sensitivity
❑ Pain	❑ Increasing constipation	❑ Thoughts of suicide / attempts
❑ Redness	❑ Persistent diarrhea	❑ Stress
❑ Loss of vision	❑ Blood in stools	❑ Irritability
❑ Double or blurred vision	❑ Black stools	❑ Poor concentration
❑ Dryness	**KIDNEY/URINE/BLADDER**	❑ Racing thoughts
HEART AND LUNGS	❑ Frequent or painful urination	❑ Hallucinations
❑ Chest pain	❑ Blood in urine	❑ Rapid speech
❑ Palpitations	**Women Only:**	❑ Guilty thoughts
❑ Shortness of breath	❑ Abnormal Pap smear	❑ Paranoia
❑ Fainting	❑ Irregular periods	❑ Mood swings
❑ Swollen legs or feet	❑ Bleeding between periods	❑ Anxiety
❑ Cough	❑ PMS	❑ Risky behavior

Please select all of the following that you have tried and *FAILED:*

Anti-depressants
- ❑ Prozac (fluoxetine)
- ❑ Zoloft (sertraline)
- ❑ Luvox (fluvoxamine)
- ❑ Paxil (paroxetine)
- ❑ Celexa (citalopram)
- ❑ Lexapro (escitalopram)
- ❑ Effexor (venlafaxine)
- ❑ Cymbalta (duloxetine)
- ❑ Wellbutrin (bupropion)
- ❑ Remeron (mirtazapine)
- ❑ Serzone (nefazodone)
- ❑ Anafranil (clomipramine)
- ❑ Pamelor (nortrptyline)
- ❑ Tofranil (imipramine)
- ❑ Trintellix (vortioxetine)
- ❑ Elavil (amitriptyline)

Mood Stabilizers
- ❑ Valproic Acid
- ❑ Tegretol (carbamazepine)
- ❑ Lithium
- ❑ Depakote (valproate)
- ❑ Lamictal (lamotrigine)
- ❑ Tegretol (carbamazepine)
- ❑ Topamax (topiramate)

Antipsychotics/Mood Stabilizers
- ❑ Seroquel (quetiapine)
- ❑ Zyprexa (olanzepine)
- ❑ Geodon (ziprasidone)
- ❑ Abilify (aripiprazole)
- ❑ Abilify Maintena Injection
- ❑ Aristada Injection
- ❑ Invega (paliperidone)
- ❑ Invega Sustenna Injection
- ❑ Invega Trinza Injection
- ❑ Clozaril (clozapine)
- ❑ Haldol (haloperidol)
- ❑ Prolixin (fluphenazine)
- ❑ Rexulti (brexpiprazole)
- ❑ Risperdal (risperidone)
- ❑ Saphris (asenapine)
- ❑ Vraylar (cariprazine)

Sedative/Hypnotics
- ❑ Ambien (zolpidem)
- ❑ Belsomra
- ❑ Lunesta (eszopiclone)
- ❑ Sonata (zaleplon)
- ❑ Rozerem (ramelteon)
- ❑ Restoril (temazepam)
- ❑ Desyrel (trazodone)

ADHD medications
- ❑ Adderall (amphetamine)
- ❑ Adderall XR (amphetamine XR)
- ❑ Concerta (methylphenidate)
- ❑ Evekeo (amphetamine)
- ❑ Focalin (dexmethylphenidate)
- ❑ Procentra (dextroamphetamine)
- ❑ Ritalin (methylphenidate)
- ❑ Strattera (atomoxetine)
- ❑ Vyvanse (lisdexamfetamine)
- ❑ Zenzedi (dextroamphetamine)

Anti-anxiety medications
- ❑ Xanax (alprazolam)
- ❑ Ativan (lorazepam)
- ❑ Klonopin (clonazepam)
- ❑ Valium (diazepam)
- ❑ Hydroxyzine
- ❑ Tranxene (clorazepate)
- ❑ Buspar (buspirone)

Substance/Alcohol Abuse
- ❑ Suboxone (buprenorphine/naloxone)
- ❑ Zubsolv (buprenorphine/naloxone)
- ❑ Bunavail (buprenorphine/naloxone)
- ❑ Subutex (buprenorphine)
- ❑ Vivitrol (naloxone) Injection
- ❑ Naloxone tablets
- ❑ Campral (acomprosate)
- ❑ Antause (disulfiram)

GAD-7 ANXIETY SEVERITY ASSESSMENT

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid, as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐

If you indicated any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with people?

☐ Not difficult at all
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult

COLUMN TOTALS: _____+_____+_____+_____ = TOTAL SCORE: _____

MOOD DISORDER QUESTIONNAIRE

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...	☐	☐
...you felt so good / hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐

PLEASE CONTINUE THIS ASSESSMENT ON NEXT PAGE

	YES	NO
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these causes you – like being unable to work; having family, money, legal troubles; getting into arguments/fights? *Please only check ONE response below:* ☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem		
4. Have any of your blood relatives (children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness "" or bipolar disorder?	☐	☐

PHQ9:

Over the last TWO WEEKS, how often have you been bothered by any of the following problems *use the scale provided to answer each question*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Thought that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐
9. Moving or speaking so slow that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
	↓	↓	↓	↓
ADD COLUMNS:				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult
☐ Very difficult ☐ Extremely difficult

PATIENT SIGNATURE PAGE (1of3)

CONSENT TO TREATMENT: Upon signing below, I hereby voluntarily give permission to any and all medical providers acting on behalf of Oluyemi Aina MD PLLC. to examine me, diagnose, and treat my medical conditions. I consent to receive medical care and services provided by Oluyemi Aina, MD PLLC.'s physicians, nurse practitioners, physician assistants, clinical nurse specialists, nurses, licensed vocational nurses, medical assistants, other health care providers, staff and/or other designees deemed appropriate to perform reasonable medical examination, testing and treatment for my conditions.

_____ _____

Signature of Patient or Guardian Today's Date

OFFICE CONDUCT: We strive to treat each patient with utmost dignity and respect. Likewise, we expect patients to show respect to our staff, providers, other patients and practice property. Disrespect of staff, providers, other patients, practice property and/or practice policies will most likely result in termination of services to a patient. We do not tolerate intimidation or threats made to anyone. Patients who threaten our staff, patients, or others in any way WILL be reported to the police, removed from the premises, and charges pressed, if deemed appropriate. _____ (Initial)

SPACE FOR PATIENTS & VISITORS: Due to space constraints and respect for patients' privacy, we request that no more than one person accompany adult patients to appointments. Patients under the age of 18 years or who have certain challenges may be accompanied by both parents. We also ask that every person in the office: patient, parent, guest or child respect the office furniture and decor at all times. Please keep feet on the floor in the waiting rooms, and be mindful of those around you. _____ (Initial)

ITEMS NOT PERMITTED: Foods, drinks, cigarettes, and electronic cigarettes are NOT permitted in our office at any time. The only animals allowed in the building will be certified and registered service animals. If you plan on bringing a service animal to your appointment, you must also bring the aforementioned documentation . _____ (Initial)

CHILDREN: In the interest of child safety and as a courtesy to other patients, it is best not to bring children to the office, unless they are our patients. We do not assume liability for minors in our building. For your child's safety, you may be asked to reschedule your appointment, if your child is poorly supervised in the office premises. All children must be adequately supervised by a responsible adult while on the office premises. _____ (Initial)

PHONES & RECORDING DEVICES: To reduce the potential risk of a Federal HIPAA Violation, the use of cell phones, tablets, recording device, cameras or photo taking is strictly prohibited, particularly while in the restroom, any portion of the back office, hallways, triage area, or any Provider's office. If you must bring a device with you for emergency purposes, it must be set to silent or on vibrate mode. For privacy reasons, you may not operate the speaker function on your phone while in the building. All phone calls must be taken outside the office. _____ (Initial)

CANCELLATION & NO SHOW FEES: We request a minimum of 24 hours advance notice for appointment rescheduling or cancellation. If advance notice is not given, there is a charge of $50.00 for canceled, missed, rescheduled or no- show appointments. This charge is the patient's responsibility. It will NOT be billed to insurance and it must be paid in full before future appointments are scheduled. _____ (Initial)

APPOINTMENTS & REMINDERS: As a courtesy to patients, our offices utilize automatic reminder messages that allow patients to confirm or cancel their appointments. On occasion, we may also send a reminder email. However, these services are a courtesy, and it is the patient's responsibility to keep track of appointment dates & times. It is also the patient's responsibility to make sure that we have the most recent telephone number and email on file, to facilitate calls or emails. _____ (Initial)

TIME: Out of respect for your time and waiting room space, we advise that you do not arrive more than 15 minutes prior to your appointment time, UNLESS YOU ARE A NEW PATIENT AND HAVE NOT COMPLETED YOUR NEW PATIENT PAPERWORK. New patients who have not completed their paperwork in advance need to arrive AN HOUR EARLY to complete paperwork. For tele-medicine appointments, paperwork must be sent to us 24 hours in advance to allow the input of information into our electronic medical record system, prior to the appointment. We try our best to stay on time for appointments, however, sometimes, patients need more time than was assigned. Please understand that our healthcare providers are committed to providing each patient with the time needed to maintain good standard of care. For this reason, appointments may run late. Please be understanding if your provider is running behind. Please arrive on time for your appointment. Patients arriving late can cause care providers to run behind. Out of respect for the time of other patients, you may be asked to reschedule, if you arrive late or send paperwork late for your appointment. _____ (Initial)

IDENTIFICATION & INSURANCE CARDS: To stay in compliance with regulations, a valid government issued photo ID and current/ active insurance card MUST be presented at your visit. We are unable to see patients if these are not presented at the visit. If you cannot provide these items, you will need to reschedule your appointment at least 24 hours in advance, to avoid the $50.00 cancellation fee. _____ (Initial)

FINANCIAL RESPONSIBILITY: All payments must be made at the time service is rendered. This includes balances, deductibles, coinsurance and/or copays. We are unable to see patients with balances or without payment. It is against the law to waive your copay or coinsurance. If you are unable to pay your portion of the visit, please call the office at least 24 hours prior to your appointment to reschedule to a date you will be able to meet your payment obligations, in order to avoid the $50.00 same day cancellation fee. Our physicians, nurse practitioners and healthcare providers do not get involved with payment for services. You may contact our billing department/ collection company with any financial questions. _____ (Initial)

INSURANCE COVERAGE: If you have insurance, it is your responsibility to call your insurance company prior to scheduling your appointment to verify your benefits and learn what is covered under your plan. You are also responsible for learning if any pre-authorization or pre-certification is required by your insurance company prior to your visit. Some services or parts of services may not be covered by health insurance. Charges for uncovered services will be your responsibility. This may include but is not limited to charges for written correspondence, reports, FMLA and other paperwork or charges for missed/canceled appointments without a 24 hours prior notification. _____ (Initial)

PRESCRIPTIONS AND SAMPLES: Please ask for your prescription or refill at the time of your appointment. Prescription refills are not automatic. They are given at the sole discretion of your healthcare provider. Your provider reserves the right to refuse any pharmacy refill request or product samples at any time. Please request refills 5 working days before you need it to ensure you receive your refill in time. _____ (Initial)

CALLS FOR THE DOCTOR: If your call relates to a medical emergency, please call 911 or go to the nearest emergency room. Please allow 48 hours for answers to questions called in for your healthcare provider. Your healthcare provider may ask a member of staff to return calls with their directions.

PATIENT SIGNATURE PAGE (2of3)

MEDICAL RECORDS: Fees for medical records are $25.00 for the first 20 pages, and $0.50 for each page thereafter and may take up to 15 business days to obtain. Report preparation fees are based on the time involved. _____ (Initial)

DISABILITY/LEAVE AND OTHER PAPERWORK: The initial fee for clinical documentation or medical paperwork supporting your disability, leave or other request is $100.00. Payment is due at the time of your request. If additional paperwork is required, an additional fee of $30.00 will be due for each follow up request. Please make your request early as completion of paperwork may take up to 15 business days. _____ (Initial)

AGREEMENT FOR CONTROLED SUBSTANCES

1. I am responsible for my medications. If the medications are lost, misplaced, or stolen, regardless of the reason, I understand that my provider WILL NOT replace or refill my medication. I further understand that early refills WILL NOT be approved. _____ (Initial)

2. I WILL NOT seek medications from any other physician or practitioner while I'm receiving the same or similar class of medications from my provider at Oluyemi Aina MD PLLC /Tri-MED. We will regularly check Prescription Monitoring Program database(s). The database tells your provider of each prescription for controlled substances that you have filled from all practitioners and pharmacies. _____ (Initial)

3. I WILL NOT seek opiate medications from any other physician or practitioner if/while I'm receiving Suboxone therapy from my Provider at Oluyemi Aina MD PLLC /Tri-MED. I further agree to inform my Provider at Oluyemi Aina MD PLLC /Tri-MED of any and all medical or dental procedures that will require the use of opiate medications. I agree to disclose the fact that I am on Suboxone therapy to to any surgical or medical provider treating me, and I will sign a Release of Information for the physicians to confer regarding medications and procedures. _____ (Initial)

4. I AGREE that refills of controlled substance medications will be requested during my scheduled visit. It is my responsibility to take the medication as prescribed. Early refills will not be granted, even if I have run out of medication early. _____ (Initial)

5. I WILL TAKE my medications as prescribed and as directed. I will not take extra medication without being advised to do so by my provider at the prescribng provider. I will not give any of my medication to anyone. _____ (Initial)

6. I WILL NOT use any illicit drugs, as defined by law. These include but are not limited to marijuana, heroin, methamphetamine, cocaine, PCP, hallucinogens, or any illegal mood altering substance. _____ (Initial)

7. I understand that to comply with regulations, random drug screening tests will be performed at my expense, to verify compliance with my treatment plan and medication contract. If I am found to be using illegal substances for any reason, my controlled substance medications will be discontinued immediately. In addition, if my urine drug screen is negative for medications prescribed by my provider(s), my controlled substances medications will be discontinued immediately and will not be re-prescribed by any provider at Oluyemi Aina MD PLLC /Tri-MED _____ (Initial)

8. I understand that if I violate any of the above conditions, for my safety, my controlled substance prescriptions will be immediately terminated. For my safety, I hereby give consent for the provider(s) at Oluyemi Aina MD PLLC /Tri-MED to report my legal/illegal medication usage and/or contract violation(s) to my other healthcare providers, medical facilities and pharmacies. _____ (Initial)

9. I understand that my provider may discontinue my medication at any time if they no longer think it is clinically appropriate or in my best interest. Additionally, if my controlled substances are discontinued by a Tri-MED provider, no other practitioner in the practice will prescribe any controlled substance to me. _____ (Initial)

10. I understand that a waiver of any of the above on any occasion, does not affect the enforceability of the same or other policies on future occasions. _____ (Initial)

REGULATION QUESTIONS/ CONCERNS MAY BE DIRECTED TO:
Call 1-888-INFO-**FDA** (1-888-463-6332). Call the **FDA** Consumer **Complaint** Coordinator for your state or region.

I acknowledge the receipt of this agreement and I have had any questions I had answered. I understand by signing below, I agree to comply with the terms and guidelines of this agreement. _____ (Initial)

Patient Name (Please Print):_____ Date:_____

_____
Signature of Patient or Guardian

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOU CAN OBTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION (PHI) AT TRI-MED, AND HOW IT MAY BE DISCLOSED AND/OR USED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND OTHER PURPOSES THAT ARE REQUIRED OR PERMITTED BY LAW. PLEASE REVIEW IT AND ACKNOWLEDGE RECEIPT BY SIGNING AND DATING THIS DOCUMENT.

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

PATIENT SIGNATURE PAGE (3of3)

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician, pharmacy, laboratory, our EMR or billing services provider, Virtual Assistant, durable medical device provider, etc., that will provide, or provides care and services to you. This ensures that the third party has the necessary information to diagnose, treat you, or provide a service needed as part of your care, diagnosis or treatment.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information may be disclosed to your health insurance provider to obtain payment or approval for coverage.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in our operations. For example, we could use your information to identify whether you could benefit from new treatment options. We may use your information to contact you or call you by your name while you are in the office.
We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.
Your Rights: Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and receive copies of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.
Our organization is not required to agree to a restriction that you may request, if our organization believes it is in your best interest to permit use and disclosure of your protected health information. In such a case, you have the right to use another Healthcare Professional and receive copies of your medical records or have your medical records sent to your chosen provider.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g. electronically.
You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
Concerns: If you have any questions or concerns regarding your HIPAA related rights at Tri-MED, please ask to speak with 'Nike Aina in person or by phone at (214) 494 2131. Our goal is to meet your needs and fulfill our legal obligations to you. If you are not satisfied and believe your privacy rights have been violated, you may complain to the OCR at the US Department of Health and Human Services, We will not retaliate against you for filing a complaint.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE RECEIVED, READ, AND UNDERSTAND MY RIGHTS UNDER HIPPA

Patient Name (Please Print):_____ Date:_____

_____
Signature of Patient or Guardian

ELECTRONIC SUBMISSIONS OF PAPERWORK:

IF YOU ARE SUBMITING THESE FORMS ELECTRONICALLY, A COPY OF YOUR VALID GOVERNMENT ISSUED I.D. AND THE FRONT AND BACK OF YOUR CURRENT INSURANCE CARD MUST BE ATTACHED AND SENT TO THE OFFICE BEFORE YOUR APPOINTMENT TIME.

Tri-MED Telemedicine Authorization Form

Patient Name: _____ DOB _____

1. PURPOSE: I understand that the purpose of this form is to obtain my consent to engage in a telemedicine consultation with my healthcare provider (s).

2. NATURE OF SERVICE: I acknowledge that my healthcare provider(s) or their representative has explained to me how the video conferencing technology will be used. I understand and accept that I will not be in the same room as my healthcare provider. I understand that there are potential risks due to the nature of telephone/videoconferencing technology, including interruptions, unauthorized access and technical difficulties.

3. RIGHTS: I understand that my healthcare provider or I can discontinue the telemedicine visit at any time.

4. CONFIDENTIALITY: I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (a) omit specific details of my medical history/ condition that are personally sensitive to me; (b) ask non-medical personnel to leave the telemedicine examination room: and or (c) terminate the consultation at any time.

5. MISCELLANEOUS: I have had the alternatives to a telemedicine consultation explained to me, and I am choosing to participate in a telemedicine consultation. I understand that some parts of my visit/exam, particularly those involving physical examinations, may be conducted by others, including my provider's supporting staff, at the direction of my provider. Some medical data such as my last known weight, review of prescriptions/ pharmacies, current contact information, insurance, and other relevant medical information may be obtained verbally by my healthcare provider or supporting staff, at the direction of the healthcare provider.

6. EMERGENT CONSULTATIONS: In an emergent consultation, I understand that the responsibility of the telemedicine provider is to advise me to call 911 or proceed to my local emergency room. My telemedicine provider's responsibility will conclude upon the termination of the phone call/ video conference connection

7. PAYMENT OF SERVICES: I understand that billing will occur from Tri-MED's offices. If I have insurance, my insurance will be billed. I am responsible for any patient portion not paid by my insurance.

8. DISPUTES: I agree that any disputes that arise from my telemedicine consult will be resolved in Texas and Texas State Law shall apply to all disputes.

By signing this form, I certify:

- That I have read this form and fully understand its contents including the potential risks and benefits of the telemedicine visit(s).
- I have had a direct conversation with my provider or a supporting staff member from Tri-MED, during which I had the opportunity to ask questions in regards to this telemedicine visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

_____ _____

PATIENT'S SIGNATURE/ GUARDIAN SIGNATURE DATE

PATIENT LAST NAME: _____
PATIENT FIRST NAME: _____
DOB: _____ S.S.NUMBER: _____
PHONE NUMBER: _____

EMERGENCY CONTACT INFORMATION:

NAME:_____ PHONE#_____ CAN WE LEAVE MESSAGE: Y N
RELATIONSHIP TO PATIENT: _____ POWER OF ATTORNEY: Y N

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION/ MEDICAL RELEASE:

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE#_____ FAX#_____
☐ ONLY RELEASE HEALTH INFORMATION ☐ ONLY RELEASE BILLING INFORMATION
☐ RELEASE ALL INFORMATION TO THE ABOVE MENTIONED ☐ ONLY RELEASE:_____

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE#_____ FAX#_____
☐ ONLY RELEASE HEALTH INFORMATION ☐ ONLY RELEASE BILLING INFORMATION
☐ RELEASE ALL INFORMATION TO THE ABOVE MENTIONED ☐ ONLY RELEASE:_____

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOU CAN OBTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION (PHI) AT TRI-MED, AND HOW IT MAY BE DISCLOSED AND/OR USED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND OTHER PURPOSES THAT ARE REQUIRED OR PERMITTED BY LAW. PLEASE REVIEW IT AND ACKNOWLEDGE RECEIPT BY SIGNING AND DATING THIS DOCUMENT.

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician, pharmacy, laboratory, our EMR or billing services provider, Virtual Assistant, durable medical device provider, etc., that will provide, or provides care and services to you. This ensures that the third party has the necessary information to diagnose, treat you, or provide a service needed as part of your care, diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information may be disclosed to your health insurance provider to obtain payment or approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in our operations. For example, we could use your information to identify whether you could benefit from new treatment options. We may use your information to contact you or call you by your name while you are in the office.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and receive copies of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request, if our organization believes it is in your best interest to permit use and disclosure of your protected health information. In such a case, you have the right to use another Healthcare Professional and receive copies of your medical records or have your medical records sent to your chosen provider.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g. electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Concerns: If you have any questions or concerns regarding your HIPAA related rights at Tri-MED, please ask to speak with 'Nike Aina in person or by phone at (214) 494 2131. Our goal is to meet your needs and fulfill our legal obligations to you. If you are not satisfied and believe your privacy rights have been violated, you may complain to the OCR at the US Department of Health and Human Services, We will not retaliate against you for filing a complaint.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE AUTHORIZED THE RELEASE OF MY PROTECTED HEALTH INFORMATION AS STATED ABOVE. MY SIGNATURE BELOW ALSO CONFIRMS THAT I HAVE RECIEVED, READ, AND UNDERSTAND MY RIGHTS UNDER HIPPA.

Patient Name (Please Print):_____

Signature of Patient or Guardian_____ Witness Signature:_____

Date:_____