Abilene Family Medical Associates

Patient Information

First Name:	Middle Name:	Last Name:	Gender: ☐ Male ☐ Female
Street Address:	City, State, Zip:	E-mail Address: *(Required)*	
Date of Birth: / /	Soc Sec #:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed	
Home Phone:	Cell Phone:	Work Phone: (please include ext.)	
What is your *preferred* method of contact? ☐ Home Phone ☐ Cell ☐ Work ☐ E-Mail ☐ Mail			
Employer: ☐ Check here if Retired	Occupation:	Referred by or how did you hear about us:	
Emergency Contact:	Contact Phone:	Relationship to Patient: ☐ Spouse/Partner ☐ Child ☐ Sibling ☐ Parent ☐ Friend	

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other Race:_____ ☐ Unreported/Refused to Report

Preferred Language: Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Unreported/Refused to Report

Pharmacy: Address: Telephone #

Financially Responsible Party

First Name:	MI:	Last Name:	Soc Sec #:	Date of Birth: / /

Relationship of Financial Party to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Address (if different from Patient): Phone:

Employed by: Occupation:

Business Address: Business Phone:

Insurance Company: Group # Subscriber/Member #

Additional Insurance

☐ **Check here if No additional Insurance and skip this section** Name Financially Responsible Party:	Soc Sec #:	Date of Birth: / /

Relationship of Financial Party to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Address: (if different from Patient): Phone:

Employed by: Occupation:

Business Address: Business Phone:

Insurance Company: Contract # Group # Subscriber #

If Patient is a Minor: By signing below, as parent, legal guardian or authorized party, I consent and authorize on behalf of the Patient, to the rendering of care and treatment, in including but not limited to medical, surgical, diagnostic, or other treatments/procedures considered necessary or advisable by employees and authorized Agents of AFMA.

By signing below you acknowledge and agree to the terms above.

Signature of Patient or Legal Guardian:	Date:
Patient Name:	

Patient Service and Fee Acknowledgement / Consent to Contact

I understand that I am financially responsible for my bill for services rendered in this office. Should this bill be sent to my insurance company for my convenience, I understand that I still remain obligated to pay the entire balance, no matter what my insurance company pays. I understand that the insurance company may not cover certain services and may also not cover a deductible, copayments and other charges. I also understand that the insurance company may also determine that certain charges were "unnecessary." This does not mean that they were medically unnecessary, but that it was unnecessary for the insurance company to pay for them. I also understand the doctor is unable to determine the amount of time it may take my insurance company to pay for services rendered. I understand, however, that in general, most insurance companies will pay for services rendered within 30 days. If my insurance company has not paid for the charges in full within 90 (ninety) days of a specific visit, I understand that the doctor may bill my for these amounts. To the extent any sums due cannot be collected, I understand that I will be responsible for any and all costs, fees and attorney's fees associated with collection thereof.

I hereby consent to AFMA using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

By signing below, I consent to the Practice: emailing me, calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person; mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment TPO, such as appointment reminder cards and patient statements. I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

ANY DISPUTE BETWEEN THE PARTIES, SHALL AT THE OPTION OF ANY PARTY, BE DETERMINED BY BINDING AND FINAL ARBITRATION BEFORE A SINGLE INDEPENDENT ARBITRATOR ADMINISTERED BY ARBITRATION SERVICES INC., ITS SUCCESSORS AND ASSIGNS, UNDER ITS ARBITRAITON RULES AT WWW.ARBITRATIONSERVICESINC.COM, EXCEPT THAT NO PUNITIVE OR CONSEQUENTIAL DAMAGES MAY BE AWARDED. These disputes may include, but are not limited to, malpractice claims, claims for money owed for services rendered and issues of arbitrability. The arbitrator shall be bound by the terms of this provision and is authorized to conduct proceedings by telephone, video or by submission of papers. By agreeing to this arbitration provision you are waiving your right to a jury trial, waiving your right to appeal the arbitration award and waiving your right to participate in a class action. Service of process or papers in any legal proceeding or arbitration between the parties may be made by First-Class Mail delivered by the U.S. Postal Service addressed to the party's address in these forms or another address provided by the party in writing to the party making service. The parties submit to the jurisdiction and laws of Florida and agree that any litigation or arbitration between the parties may be commenced and maintained in Palm Beach County, Florida. **YOU ACKNOWLEDGE THAT THIS PROVISION TO ARBITRATE DISPUTES AND ANY SUBSEQUENT ARBITRATION BETWEEN THE PARTIES IS BINDING AND FINAL AND THAT YOU ARE WAIVING YOR RIGHT TO TRIAL IN A COURT OF LAW AND OTHER RIGHTS.**

BY SIGNING BELOW, I AGREE TO THE FINANCIAL AND CONTACT POLICIES OF THE PRACTICE SET FORTH HEREIN.

_____ _____

Signature of Patient or Legal Guardian Email Address

_____ _____ _____

Patient's Name Date Phone (Cell/Home/Work)

Advanced Directives

Advanced Directives: A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Do you have a living will? ☐ Yes ☐ No If yes – please provide a copy to the Clinic

Do you have a durable power of attorney? ☐ Yes ☐ No If yes – please provide a copy to the Clinic

Do you have a legal document designating anyone (other than your family/guardian) to make health decisions for you in the event you are incapacitated and cannot make them for yourself? ☐ Yes ☐ No

If Yes: Name: _____ Phone: _____ Are they aware of your choice ☐ Yes ☐ No

Would you like a copy of Advance Directive Information ☐ Yes ☐ No

Consent for Treatment

General Consent for Treatment: I hereby consent and authorize to the rendering of care and treatment, including but not limited to medical, surgical, diagnostic, or other treatments/procedures **("Treatments")** considered necessary or advisable by employees and authorized agents of the Abilene Family Medical Associates.

General Acknowledgments: I understand that the practice medicine in is not an exact science. I understand the medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results for my examinations or Treatments. I understand and agree that I may be observed and/or receive care from medical, nursing and other health care students in training at Abilene Family Medical Associates. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by Abilene Family Medical Associates.

I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Abilene Family Medical Associates to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Right to Refuse Treatments: I understand that I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments.

_____	_____	_____	_____
Signature of Patient/Responsible Party	Date	Print Name	Relationship to Patient

PATIENT CONTRACT

Welcome to the Abilene Family Medical Associates. We are committed to our patient's health and wellness. In return for our commitment to you, our patient, we require you acknowledge and adhere to AFMA's basic operating procedures, set forth in this Patient Contract, as follows:

_____ *(initial)* AFMA will offer you access to your own personal patient portal where you can obtain your records and contact the office. The portal can be used to message your provider, request appointments or referrals, and to manage your prescriptions. The portal is not for urgent issues, messages sent through the portal will not be checked until the next business day. Please provide your email address for this function.

_____ *(initial)* AFMA is open Mon-Thur: 8:00 am to 5:00 pm & Fri 8:00am-1:00pm. Urgent same day appointments may be available with your provider. For emergencies please call 911 or go to the nearest ER. To contact the on-call provider after hours please call: 325-671-5240 and follow prompts. This service is available for urgent matters and is not for routine calls or prescription refills. Please note hours of operation may change at discretion of AFMA.

_____ *(initial)* In order to keep your records accurate and avoid potentially harmful drug interactions, we may need to verify your medications through an external database or with your pharmacist. This allows AFMA providers to know what medications other doctors have prescribed for you.

_____ (*initial*) I agree to arrive on time to my appointment (we recommend 15 min early for existing pt or 30 min for new patients); AFMA requires 24-hour notice if I am unable to keep my appointment, I understand that missed appointments with less than 24-hour notice may incur a fee of **$50.** Missed appointments for lab may result in cancellation and rescheduling of the corresponding follow-up.

_____ (*initial)* Labs and diagnostic tests ordered prior to your visit or at your visit may require an additional follow-up appointment with your provider to discuss results. If you are unable to keep your scheduled appointment you will be required to reschedule to discuss your results.

_____ *(initial)* I hereby consent that I will not use any recording device of voice or image on the premise of AFMA. This includes but is not limited to cameras, voice recorders, phones and Google glasses.

_____ *(initial)* I acknowledge and agree that I have received a copy of AFMA's Privacy Practices.

_____ *(initial)* I understand and agree that I may be observed and/or receive care from medical, nursing and other health care students in training at AFMA.

_____ *(initial)* I understand that the practice medicine in is not an exact science. I understand the medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results for my examinations or treatments. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by AFMA.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

ABILENE FAMILY MEDICAL ASSOCIATES

Agreement of Financial Responsibility

The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s), coinsurance or deductible(s) which are payable at time of service, and then bill you for any remaining amount determined to be your responsibility by your insurance company. Any balance you owe that remains unpaid 90 days after you were billed will be transferred to a collection agency for recovery.
- If we do not contract with your insurance company, we will prepare and submit your claim for you on an assigned basis. Please be aware that we are not contractually obligated to accept any adjustments from your insurance carrier. Any amounts determined to be "Patient Responsibility" and not collected at time of service will be billed to you and payment is due upon receipt of statement from our office.
- Proof of coverage and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Fee for Service

_____ (*initials*) I agree to pay my account at the time service is rendered or will make financial arrangements satisfactory to AFMA for payment. If my account is sent to collections, I agree to pay collection expenses, court fees and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any party liable to the patient, is hereby assigned to AFMA. If Co-payments and/or deductibles are designated by my insurance company or health plan; I agree to pay them to AFMA. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Non-Covered Services:

_____*(initials)*I understand that AFMA contracts with health care plans which specifically state services which are "covered" by the health care plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care service plans not to be covered. I agree to cooperate with AFMA to obtain necessary health care service authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party **Date**

_____ _____

Name of Patient/Responsible Party (please print) **Relationship to Patient**

MRN: _____

Assignment of Benefits Form

ASSIGNMENT OF BENEFITS

I hereby authorize my contracted insurance company, previously identified, to pay and to mail directly to Abilene Family Medical Associates the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to Abilene Family Medical Associates any benefits under any policy of insurance, indemnity agreement, or any other collateral source.

This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company ("Insurer") for services that I have received and all rights to proceed against my insurance company in any action including legal suit of for any reason by insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the Health Care Provider as my assignee.

I authorize the release of any medical information necessary to process this claim. A photocopy of this document shall be as binding as an original signature page.

MEDICARE PATIENTS ONLY:

AFMA accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to AFMA. If I receive payment, then I am responsible to provide payment and EOB to AFMA upon receiving such payment.

Patient's Signature: _____ Patient's Name: _____ Date: _____

Personal and Family History

Patient Name _____ **DOB** _____ **Date** _____

Family History

Family Member	Age	Age at Death	Cause of Death	Condition	Family Relationship	Condition	Family Relationship
Mother				Allergies		Eating Disorder	
Father				Anemia		Glaucoma	
Brother				Alcoholism		Heart Attack	
Brother				Arthritis		Hepatitis	
Sister				Asthma		HIV/AIDS	
Sister				Arrythmia		Hypertension	
Son				Blood Clots		Kidney Disease	
Son				Birth Defects		Liver Disease	
Daughter				Depression		Migraines	
Daughter				Cancer: Breast		Nervous Breakdown	
				Cancer: Colon		Obesity	
				Cancer: Lung		Psych Disorder	
Women Only				Cancer: Prostate		Stomach Ulcer	
1st Menses				Cancer: Other		Stroke	
Frequency				Colitis		Suicide	
Duration				COPD		Thyroid	
Menopause				Dementia		Tuberculosis	
				Diabetes		Other	
				Drug Addiction		Other	

Personal History

Immunization	Circle	Date	Surgical History	Year
Flu	Y N			
Pneumonia	Y N			
Tetanus	Y N			
Hepatitis B	Y N			
Hepatitis A	Y N			

Habits	Daily Average	Habits	Circle: 5=always, 1-never	Comments
Smoking		Exercise Regularly	5 4 3 2 1	
Coffee		Wear Seat Belt	5 4 3 2 1	
Alcohol		Chew Tobacco	5 4 3 2 1	
Beer		Binge Eat	5 4 3 2 1	
Laxatives		Skip Meals	5 4 3 2 1	
Drugs		Experience Stress	5 4 3 2 1	

Past Personal History- Circle all that apply

Asthma	Chest Pain	Endometriosis	HIV/AIDS	Pleurisy	Stomach Ulcer
Allergies	Cholesterol Prob	Gallstones	Kidney Stones	Phlebitis	Seizures
Anemia	Colitis	Glaucoma	Mitral Prolapse	Rheumatic Fever	Thyroid/Goiter
Angina	COPD/Emphysema	Hypertension	Migraines	Rheum Arthritis	Tuberculosis
Alcoholism	Depression	Hepatitis	Obesity	STDs	
Arrythmia	Diabetes	Heart Attack	Osteoarthritis	Stroke	
Blindness	Drug Addiction	Heart Murmur	Osteoporosis	Skin Disease	
Blood Clots	Enlarged Heart	Hemorrhoids	Pneumonia	Scarlett Fever	

AFMA
ABILENE FAMILY MEDICAL ASSOCIATES

Review of Systems

NAME:_____ DOB: _____ Date:_____

Please circle if you are currently experiencing any of the following symptoms in each category.

General	Fever, Weight Gain, Weight Loss, Appetite Change, Night Sweats, Fatigue, Chills
Eyes	Blurry, Double Vision, Vision Loss, Tearing, Redness Pain, Sensitivity to Light Glaucoma
Ears, Nose, Mouth, Throat	Hearing Loss, Ringing in Ears, Ear Pain, Nosebleeds, Nasal Congestion, Nasal Drainage, Tooth Problems, Mouth/Throat Irritation
Cardiovascular	Chest Pain/Pressure, Heart Racing, Palpitations, Sweating, Leg swelling, High/Low Blood Pressure
Pulmonary	Cough, Yellow/Green Mucus, Blood in Mucus, Shortness of Breath, Wheezing, Snoring
Gastrointestinal	Nausea, Vomiting, Diarrhea, Constipation, Pain, Blood in Stool or Vomitus, Heartburn, Jaundice, Difficulty Swallowing
Genitourinary	Incontinence, Abnormal Bleeding, Blood in Urine Abnormal Discharge, Urinary Frequency, Urinary Hesitancy, Pain, Impotence, Sexual Problem, Infection, Urinary Retention, Bedwetting,
Musculoskeletal	Pain, Stiffness, Joint Redness/Warmth, Arthritis, Back Pain, Weakness, Muscle Wasting, Sprain/Fracture, Falling
Neurological	Headache, Weakness, Dizziness, Change in Voice, Change in Taste, Change in Vision, Change in Hearing, Loss/Change in Sensation, Trouble Walking, Balance Problem, Coordination Problem, Shaking, Speech Problem, Memory Loss, Confusion, Tremors, Unsteadiness, Tingling
Endocrine	Cold/Heat Tolerance, Blood Sugar Problem, Weight Gain/Loss, Missed periods, Hot Flashes/Sweats, Change in Body Hair, Change in Libido, Increased Thirst, Increased Urination
Heme/Lymph	Swelling, Bleeding Problem, Anemia, Bruising, Enlarged Lymph Nodes
Allergic/Immunologic	Itch, Post Nasal Drip, Watery/Itchy Eyes, Immunosuppressed
Psychiatric	Depression, Anxiety, Hallucinations, Insomnia

Note this is a NPP that reflects Omnibus changes as of March 2013

ABILENE FAMILY MEDICAL ASSSOCIATES, LLP

NOTICE OF PRIVACY PRACTICES

Effective Date: September 1, 2013

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.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:

Privacy Officer Phone Number: Office Administrator – (325) 695-6370 Extension 113

Section A: Who Will Follow This Notice?

This Notice describes **Abilene Family Medical Asssociates, LLP** (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information about You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you about raising money for the Provider. We

only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'Opt-out' of these communications.

- **Authorizations Required**
  We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

- **Psychotherapy Notes**
  Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **Provider Directory.** We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

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

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **E-mail Use.**
  E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail through the Practice's web based Patient Portal is encouraged. You may access the patient portal at www.abilenedocs.com.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release 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.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - 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; and
  - 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.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release 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 patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information about You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that 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 or for the Provider. In addition, you must provide a reason that supports your request.

- 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:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **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 payment or healthcare operations. You also have the right to request a limit 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. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

  You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

    - a brief description of the breach, including the date of the breach and the date of its discovery, if known;
    - a description of the type of Unsecured Protected Health Information involved in the breach;
    - steps you should take to protect yourself from potential harm resulting from the breach;
    - a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;

- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **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 work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **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. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website. www.abilenedocs.com.

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. 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. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services;
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have

ABILENE FAMILY MEDICAL ASSOCIATES
PATIENT ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM (HIPPA OMNIBUS RULE)

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***Print*** patient name Please ***sign*** your name

_____ _____

Legal Representative if signing for minor/other Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patients records):

1) Name: _____ Relationship: _____

Phone number_____

2) Name: _____ Relationship: _____

Phone number_____

3) Name: _____ Relationship: _____

Phone number_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT, AND BILLING INFORMATION VIA:**

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ Text message to my Cell ☐ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:**

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ Text message to my Cell ☐ **Any of the above**

By signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote you improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office use only: As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because: ☐ It was emergency Treatment ☐ I could not communicate with the patient ☐ the patient refused to sign ☐ the patient was unable to sign because other (please describe) _____

Signature of Privacy Officer: _____ Date: _____

Abilene Family Medical Associates
6417 Central Park BLVD,
Abilene, TX 79606
(325) 695-6370 Fax: (325) 695-1505

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

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 a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Abilene Family Medical Associates
Address 6417 Central Park Blvd.
City Abilene State TX Zip Code 79606
Phone (325) 695-6370 Fax (325) 695 1505

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

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, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/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 majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization 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 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 X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

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. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.