Greater Texoma Health Clinic

## WELCOME TO YOUR MEDICAL HOME

The Greater Texoma Health Clinic would like to thank you for choosing our clinic and providers for your primary care needs. Our Mission is to provide low cost comprehensive health and wellness services to residents of the Texoma community. Our Vision is to ensure a healthcare system that provides Quality, Cost-effective, Accessible and Comprehensive Health care to all citizens of the Texoma community. Below you will find our office policy regarding Insurance, Medicare and Medicaid, CHIPS and our sliding fee scale , assignment of benefits and No Show policy.

- All patients are required to complete a new patient packet before being seen for the first time.
- All fees are due at the time of service unless prior arrangements have been made in advance.
- We accept two methods of payment: Cash or check. Should your check be returned unpaid by your financial institution, there will be a service fee charged to your account.
- At anytime during your care with us please notify our office of any changes in your personal information such as income, address, phone number, employment, etc. You may be asked to update your information form at the beginning of each calendar year.

**Insurance we accept**

We currently accept Traditional Medicare, Care Improvement Plus, Traditional Medicaid, Amerigroup, Superior Health Plan and CHIPS. We do not accept any private insurance. A current insurance card is required and any co-payment and/or deductible are due at the time of your appointment.

**Sliding Fee Scale**

In order to provide fair and legal payment options for all patients, we must use the nation poverty level guidelines published by Health And Human Services as a guide. We offer hardship adjustments on a sliding scale based on these guidelines and the supporting documentation that you provide with your application.

### Insurance Authorization and Assignment of Insurance Benefits

I hereby authorize the Greater Texoma Health Clinic to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to be by any Greater Texoma Health Clinic provider. I further agree that this authorization to release information and assignment of benefits shall remain in effect for one calendar year unless and until it is revoked in writing by me.

### No Show Appointments

- Patients are required to cancel their appointment no less than 24 hours prior to the scheduled appointment date/time. Failure to give 24 hour notice is considered a “No Show” for purposes of this policy.
- As new patient after two no shows you are no longer eligible to be seen at the Greater Texoma Health Clinic.
- As an established patient if there are 3 no-shows in a 12 month period, Greater Texoma Health Clinic reserves the right to dismiss you from the practice. Should this happen you will receive 30 days of care while you seek a new provider.
- Appointments scheduled the same day appointments must give 2 hours notice to cancel or reschedule. If not, this will be considered a “No Show” for purposes of this policy.

| Signature of Patient/Parent/Legal Guardian | Date |
|---|---|
| | |

Greater Texoma Health Clinic

**PATIENT REGISTRATION FORM**

PATIENT NAME:_____
(Last Name) (First Name) (Middle Name)

GUARDIAN NAME:_____
(Last Name) (First Name) (Middle Name)

ADDRESS:_____
(Street Address) (City) (State) (Zip Code)

HOME PHONE:_____EMAIL ADDRESS:_____

SEX: ___MALE___FEMALE BIRTHDATE:_____SSN:_____

LANGUAGE:___ENGLISH___SPANISH___OTHER:_____EDUCATION YEARS:_____

RACE:___CAUCACIAN___AFRICAN-AMERICAN___OTHER_____
ETHNICITY:___HISPANIC___NOT HISPANIC INTERPRETER NEEDED___YES___NO
STATUS:___SINGLE___MARRIED___SEPERATED___DIVORCED___WIDOWED

**RESPONSIBLE PARTY**

EMPLOYMENT:
___FULL TIME ___PART TIME___UNEMPLOYED___SELF-EMPLOYED___STUDENT___VETERAN

NAME:_____HOME PHONE:_____
(Last Name) (First Name) (Middle Name)

EMPLOYER NAME:_____EMPLOYER PHONE:_____

EMPLOYER ADDRESS:_____
(Street Address) (City) (State) (Zip Code)

**EMERGENCY CONTACT**

CONTACT NAME:_____PHONE #_____

***I attest this information is true and accurate***

PATIENT SIGNATURE:_____DATE:_____

SIGNATURE OF PERSON GRANTING CONSENT:_____

RELATIONSHIP TO PATIENT:_____

Greater Texoma Health Clinic

# Notice of Privacy Practices

*This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.*

Protected health information, about you, is maintained as a record of your contacts or visits for healthcare services with our practice. Specifically, "protected health information" is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Our practice is required to follow specific rules on maintaining the confidentiality of your protected health information, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. A revised Notice of Privacy Practices may be obtained by calling the office and requesting that a copy be mailed to you, or asking for one at the time of your next appointment.
If you have any questions about this Notice, please contact our Privacy Manager.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

- You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

- You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

- You have the right to designate a personal representative – This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

- You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines.

- You have the right to request a restriction of your protected health information - This means you may ask us, in writing, 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. In certain cases, we may deny your request for a restriction.

- You may have the right to request an amendment to your protected health information – This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

- You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your protected health information, to entities or persons outside of our office.

## How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other Healthcare Providers who may be involved in your care and treatment.

- We may also call you by name in the waiting room when your Healthcare Provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.

- Payment - Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

- Healthcare Operations - We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

- Regional Information Organization - The practice may elect to use a regional information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

## Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

- To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death.

If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Healthcare Provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

- As Required By Law - We may use or disclose your protected health information to the extent that is required by law.

- For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

- For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.

- To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, to monitor product defects or problems, to report biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.

- For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- To Law Enforcement - We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.

- To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

- For Research - We may disclose your protected health information to researchers when an institutional review board has reviewed and approved the research proposal and established protocols to ensure the privacy of your protected health information.

- In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information, if it is necessary for law enforcement authorities, to identify or apprehend an individual.

- For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel:

(1) for activities deemed necessary by appropriate military command authorities;
(2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or
(3) to foreign military authority if you are a member of that foreign military service.

- For Workers' Compensation - Your protected health information may be disclosed as authorized to comply with workers' compensation laws and other similar legally-established programs.

- When an Inmate - We may use or disclose your protected health information if you are an inmate of a correctional facility and your Healthcare Provider created or received your protected health information in the course of providing care to you.

- Required Uses and Disclosures - Under the law, we must make disclosures about you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our aCEO or Practice Administrator

Greater Texoma Health Clinic
900 North Armstrong
Denison, Texas 75020
903-465-2440

**HIPAA AUTHORIZATION USE OR DISCLOSURE OF HEALTH INFORMATION**

Patient Name:_____Patient D.O.B._____

Cell phone:_____Home phone:_____Work phone:_____

I authorize The Greater Texoma Health Clinic to leave messages with medical information on voicemail/answering machine at:

_____Cell Phone _____Home Phone _____Work Phone

I authorize the following individual(s) to receive information pertaining to my medical history and treatment received:

Name:_____Relationship:_____

Name:_____Relationship:_____

In accordance with the Privacy Rule of the Health Care Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf and delivered to The Greater Texoma Health Clinic (900 N. Armstrong, Denison, Tx. 75020). My revocation will be effective cone received by The Greater Texoma Health clinic.
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules
3. My authorized representative will be required to provide legal documents to prove their ability to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Signature:_____Date:_____

**OR**

Authorized representative name:_____Relationship:_____

Authorized representative signature:_____Date:_____

**PATIENT RIGHTS, AUTHORIZATION AND MEDIA CONFIRMATION FORM**

Name:_____ DOB:_____Date:_____

I confirm that I have received a copy of the Patient Rights and Responsibilities documentation and I have had the opportunity to ask questions and have them answered.

Signature:_____Date:_____

**Authorization for Medical Treatment**

I hereby authorize the Physicians, Physician's Assistants, Nurse Practitioners, and Nurses on staff at GTHC to provide medical, nursing and general patient care or such treatment as necessary.

I understand the Nurse Practitioners or Physician Assistant is not a Physician, and that I have the right to insist at any time on seeing the supervising Physician.

I understand that a minor must be accompanied by a Parent, Legal Guardian or authorized representative for every medical visit.

I understand that this consent form will be valid and remain in effect as long as I (he/she) attend GTHC.

This form has been fully explained to me and I understand its contents.

_____ _____

Signature of Parent or Legal guardian Date

**Authorization to Consent to Treatment of a Minor Child**

I hereby authorize_____

(An adult into whose care the minor has been entrusted) to consent to any medical or surgical diagnosis or treatment, x-ray, laboratory and hospital care of _____name of minor deemed advisable by a licensed Physician, Physician Assistant or Nurse Practitioner and provided by that provider or under that provider's supervision, regardless of where that treatment is provided.

**This authorization is made under Texas Family Code 32.001**

_____ _____

Signature of Parent or Legal guardian Date

_____

Printed Name

Your Relationship to minor child:

____Parent w/legal Custody

____Guardian w/legal custody

____Caregiver designated by parent/legal guardian

**GREATER TEXOMA HEALTH CLINIC**
**900 NORTH ARMSTRONG**
**DENISON, TEXAS 75020**
**903-465-2440 (OFFICE) 903-465-2298 (FAX)**

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____
Last name if different when treated:_____Date of birth_____
Address:_____
(Street address) (City) (State) (Zip code)
SS#_____Patient's phone #_____
Date of request:_____Date Needed:_____

I hereby authorize_____to release information and forward to:
(Provider)
Provider Name:_____
Provider Address_____
(Street address) (City) (State) (Zip code)

**Please check the type of information to be released**

| | | |
|---|---|---|
| **Complete Medical Record** | **Lab results** | **X-ray results** |
| **Notes/Results for date of service** | **Consultation reports** | **Billing record** |
| **Immunizations** | **Other, Specify** | |

**Please check the reason the above information is released**

| | | |
|---|---|---|
| **Transfer to another physician** | **Legal Purposes** | **Specialist/2nd Opinion** |
| **Personal file** | **Disability benefits** | **Other, specify** |

- I understand that the specific information to be disclosed may include history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.
- I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
- However, no protected information will be released without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy of Individually Identifiable Health Information (45 CFR parts 160 & 164).
- I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire in 180 days from the date of my signature on or otherwise specified by date, event or condition as follows:_____
- I further authorize that a photocopy of this original is acceptable as an original.
- I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing law.

**Divorced Parents:** This is to certify that I, _____, have full access to my child's medical record according to the divorce decree granted by the court.
*Patient/Parent/Guardian Name:
*Patient/Parent/Guardian Signature:

***Signature of Patient or Legal Representative***_____ *Date* _____
***Relationship to Patient*** _____
*Identity of Requestor Verified via: Photo ID Matching Signature Other, specify*
*PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal & State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in case of a first offense, and not more than $5,000 in the case of each subsequent offense.*

**Date of Request**: ___/___/___ Record **copying cost: $**_____**.00** _____ Cash _____ Check#_____ _____ C.C.

# Adult Patient Intake Form

Name:_____ DOB:_____Date:_____

Please fill out the following information:

Previous Doctors office: _____ Phone:_____
_____ Phone:_____
_____ Phone:_____
_____ Phone:_____

What brings you to the office:_____

Preferred pharmacy:_____

If you were not able to be seen here would you have gone to the ER? _____Yes_____No

How did you hear about our clinic:_____

## Past Medical History

**Allergies:**
Medicine:_____Foods_____Insects_____

Broken bones, fractures, sprains:_____
_____

**Personal Habits:**

1. Do you exercise regularly? (3-4 times a week)? YES/NO
2. Do you use illegal drugs? YES/NO
3. Do you drink alcohol? YES/NO
   If yes, how many_____
4. Do you smoke? YES/NO
   If yes, how many_____
5. Do you use chewing tobacco YES/NO
6. How many caffeine drinks do you drink daily? _____
7. Do you have an eating disorder? YES/NO
8. Have you been physically abused? YES/NO
9. Do you feel safe at home? YES/NO
10. What form of birth control are you using, if any? _____

**Please list all surgical procedures and/or hospital stays and the dates**:

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

My signature indicates that the above information is true and correct to the best of my knowledge.

Signature_____ Date:_____

## Adult Patient Intake Form Continued

**Have you ever been diagnosed as having the following? Check all that apply**

__AIDS or HIV+
__Anemia
__Anxiety/Depression
__Arthritis
__Asthma
__Bleeding diseases
__Blood clots
__Cancer
__High Cholesterol
__Diabetes
__Epilepsy/Seizures
__Glaucoma
__Heart Disease
__Hepatitis A, B, or C
__High Blood Pressure
__Kidney disease
__Mental Illness
__Migraine Headaches
__Sickle Cell Anemia
__Stroke
__Thyroid Disease
__Tuberculosis/Lung
__Ulcers
__Venereal Disease

**Has a member of your family had the following:**

__Cancer
__Diabetes
__Epilepsy/Seizures
__High Blood Pressure
__Heart Disease
__Tuberculosis/Lung

**TESTS (give date last done)**

| Test | Year Performed | Not sure | Never done | Results |
|---|---|---|---|---|
| Lead | | | | |
| Hemoglobin | | | | |
| Rubella | | | | |
| Triglycerides | | | | |
| Thyroid profile | | | | |
| Tetanus (DPT) | | | | |
| Cholesterol | | | | |
| Blood sugar | | | | |
| Vision | | | | |
| Hearing | | | | |

**Menstrual Periods:**

Age onset:_____ Date of last period:_____

Periods: (circle one) Regular Irregular Difficulty with periods

My signature indicates that the above information is true and accurate to the best of my knowledge.

Signature_____ Date:_____

**Medication List( Prescribed and Over the counter)**

Name:_____ DOB_____Date_____

Allergies:_____Preferred Pharmacy_____

| | Date started | Medication | Dose | Frequency | Last refilled |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
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| 11 | | | | | |
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| 13 | | | | | |
| 14 | | | | | |
| 15 | | | | | |