NORTH HILLS FAMILY MEDICINE

Which provider have you chosen as your PCP? (Please check one)
❑ Dr. G. Fuller ❑ Dr. J. Gabriel
❑ Dr. P. Martin ❑ Dr. J. Lambert

Today's Date: _____/_____/_____

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	Apt #	City	State	ZIP Code	Home ❑ Preferred

Social Security Number	Preferred Language	Ethnicity ❑ Hispanic ❑Non-Hispanic	Race	Cell ❑ Preferred

Occupation	Employer	Employer Phone No. ❑ Preferred
If a minor	Legal Guardian	Phone Number

INSURANCE INFORMATION (if applicable)

Primary Insurance Company		**Secondary** Insurance Company	
Subscriber Name (Policy Holder)	Relationship to Patient	Subscriber Name (Policy Holder)	Relationship to Patient
Subscriber Social Security #	Subscriber DOB	Subscriber Social Security #	Subscriber DOB
Policy Number		Policy Number	
Name of Employer		Name of Employer	
Work Phone	Home Phone	Work Phone	Home Phone

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.

If you see any additional specialists, please list them below with phone number:

Notice: Payment is due at the time of service.

I hereby authorize the release of any Medicare, medical, and non-medical information necessary to process my medical claims and I request payment of insurance benefits to North Hills Family Medicine for all services rendered at this Clinic. I also understand that any fees incurred at North Hills Family Medicine which are not covered by my insurance company are my financial responsibility. I agree to provide North Hills Family Medicine with current insurance information that is necessary to file any claims for services or procedures performed. I understand that failure to do so will result in the charges being my financial responsibility. North Hills Family Medicine reserves the right to charge certain fees for returned checks, failure to pay copay, no show appointments and balances not paid in full within 60 days of their becoming due and payable. (More information on any fees can be found in our financial policy). The policies of North Hills Family Medicine are not subject to change by anyone other than the management of North Hills Family Medicine.

I also consent, voluntarily, to be a patient and receive medical treatment at North Hills Family Medicine.

My signature below indicates that I have read and understand the above policy.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Please Circle One: Self Spouse Parent/Guardian Grandparent Other_____

FINANCIAL POLICY AND PATIENT CONSENT FORM

North Hills Family Medicine, PA ("NHFM") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services Please read our Financial Policy and Patient Consent Form and initial where indicated.

CONSENT TO MEDICAL CARE: I request treatment by NHFM and it's agents and employees. I consent to the procedures which may be performed during my course of treatment, including laboratory services, x-ray examination, diagnostic procedures, or minor surgical treatments/procedures. I voluntarily consent to treatment. I understand that I am free to withdraw my consent and to discontinue treatment at any time. However, I understand that doing so may hinder my treatment and/or medical outcome.

_____ Initial

PAYMENT: Payment is due in full at time of service. This includes deductible, co-insurance, copay and any % that is your share or not covered by your insurance plan.

_____ Initial

CO-PAYMENTS: All managed care (HMO, PPO, etc) co-payment amounts are due in full at the time of service. <u>You will be charged a $10 billing fee if you do not pay your Co-Payment on the day of your visit.</u> For your convenience we accept cash, check, Visa, MasterCard, Discover, and American Express.

_____ Initial

JEFFERSON INDEPENDENCE CARD: We are accepting the Jefferson Independence Card discount program. This program offers discounts on most of the services we offer. Registration for Jefferson Independence Card is easy to access online and is simple to fill out, you can get to the website directly at http://www.jeffersonicard.com or go to http://www.nhfm.net and click on Jefferson Independence Card under the Insurance Section. ***This program is only for those individuals that do not have insurance, all Jefferson Independence Card discounts will be null and void if there is any other insurance coverage in effect on the date of the visit.***

_____ Initial

CANCELLED APPOINTMENTS: If you are scheduled for an appointment that is not for an acute illness (i.e. cold, flu, injury, etc) and are unable to keep your scheduled appointment, please call our office no later than 24 hours prior to your appointment time to reschedule your appointment. **NHFM will charge a $25 fee for failure to keep these appointments. This fee will not be covered by your insurance and you will be required to pay this in full.** ***A third no show may result in dismissal from the practice.***

_____ Initial

ROUTINE EXAMS: Many insurance companies cover your yearly physical/well woman exam at 100% with no copay. Commonly, patients wish to discuss additional medical problems during their physical exam, when this occurs, further evaluation and treatment becomes necessary. In lieu of having you schedule another appointment, our providers will often manage your problem(s) at this time. This includes addressing ongoing medical conditions such as hypertension, diabetes, high cholesterol, and depression just to name a few. Discussion of these medical issues at the same time as your routine visit may be viewed by your insurance carrier as an additional encounter. **This additional encounter may be subject to your usual office visit charge or copay.**

_____ Initial

PATIENT RESPONSIBILITY: We participate in many insurance plans. It is your responsibility to become familiar with your insurance benefits and confirm our participation with your plan. Please contact your insurance company with any questions you may have regarding your coverage. If the services you receive are not covered by your insurance you will be responsible for all of the charges for the visit. **Your initials indicate your understanding that it is your responsibility to be aware of what services are covered and that, further, you agree to pay for any service(s) deemed to be non-covered or not authorized by the plan.**

_____ Initial

PROOF OF INSURANCE: Please bring your current, valid insurance card and a photo ID with you to every visit. We must obtain a copy of your insurance card and photo ID at the time of your visit. If we are unable to verify your current insurance information you will be required to pay the visit in full at the time of service.

_____ Initial

FINANCIAL POLICY AND PATIENT CONSENT FORM CONT.

MEDICARE: The physicians at NHFM are participating providers with the Medicare program. The Keller location has several providers that accept new Medicare patients and our North Richland Hills location is limited to existing patients only. We accept as payment the patient Medicare allowable, your deductible and/or 20% co-insurance. If you have supplement insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare or secondary payers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In the case of a non-covered service you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

Initial

CLAIMS SUBMISSION: As a courtesy, we will submit your claims to your insurance carrier. Your insurance carrier may require additional information from you in order to process the claim. **Failure to comply with their request for information within 30 days will result in full patient responsibility for the claim.**

Initial

DISABILITY OR INSURANCE FORMS: There will be a charge for the completion of medical forms. Pre-payment is required prior to the forms being completed. Please allow 5-7 business days for the completion of these forms.

Initial

MINORS: If the patient is a minor, he/she must be accompanied by Parent/Legal Guardian for each office visit. If the patient is to be seen without the parent/legal guardian, minor consent must be given in writing and signed by Parent/Legal Guardian prior to the patient being seen.

Initial

CHILDREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of NHFM.

Initial

CLINICAL RESEARCH: NHFM participates in clinical research studies, and NHFM physicians are compensated (receive money) by the study sponsors to perform research trials. Patient authorizes NHFM to access his/her medical information for the purpose of evaluating eligibility of patient for current or future clinical research studies. Patient agrees to be contacted by NHFM regarding the possibility of being enrolled in a research study. Patient is under no obligation to enroll in any study. Study participation is voluntary and refusal to participate in a research study will not affect your continuing care with any provider at NHFM. Participation in a research study will not interrupt your regular care with any provider at NHFM.

Initial

ACKNOWLEDGEMENT TO RECEIVE PAST MEDICATION HISTORY: I authorize NHFM agents and employees to electronically obtain my current and past medication history. This may include a history of HIV, psychiatric or pain medications.

Initial

PATIENT PORTAL: I understand NHFM uses an online patient portal. I understand I may access this at any time through the website, www.nhfm.net, to see my current information, renew/refill prescriptions, view and request appointments. I understand this is to be used for non-emergent issues only.

Initial

AUTOMOBILE ACCIDENTS: We do treat automobile accident patients. However, we do not bill other insurances. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance patment

Initial

It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please feel free to contact one of our offices below:

North Richland Hills Office
4351 Booth Callow Road, Suite 101
North Richland Hills, Texas 76180
(817) 284-1165

Keller Office
300 North Rufe Snow Drive
Keller, Texas 76248
(817) 431-3800

NORTH HILLS FAMILY MEDICINE

NEW PATIENT MEDICAL HISTORY FORM

Today's Date: _____

NAME: _____ **SEX:** _____ **DOB:** _____ **AGE:** _____

EMAIL ADDRESS: _____

REASON FOR VISIT TODAY: _____

PHARMACY NAME: _____ **ADDRESS/CROSS STREET** _____

ALLERGIES (Include medications, foods, x-ray dyes and list type of reaction) or ❑ NONE KNOWN

1.	**3.**
2.	**4.**

CURRENT MEDICATIONS (Include prescriptions, over the counter, and herbal supplements. Attach extra sheet if necessary) or ❑ NONE

(List Name of mediation, dose and how often taken)

1.	**4.**
2.	**5.**
3.	**6.**

MEDICAL PROBLEMS (list your long-term medical problems. Attach extra sheet if necessary)

PREVIOUS HOSPITALIZATIONS (Include all non-surgical hospitalizations, Attach extra sheet if necessary) or ❑ NONE

Reason for hospital stay	Date (approx.)	Hospital or City if known
1.		
2.		

SURGERIES (include all surgery in your lifetime. Attach extra sheet if necessary) or ❑ NONE

Type of surgery	Date (approx.)	Hospital or City if known
1.		
2.		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual Cycle: _____

TOBACCO, ALCOHOL AND DRUG HISTORY

Are you an active cigarette smoker? ❑ Yes ❑ No Have you ever been a cigarette smoker? ❑ Yes ❑ No,

If yes, I smoke/smoked an average of _____packs/day for _____years. I quit in _____ (year)

Do you use other tobacco products? ❑ Yes ❑ No If yes, please specifiy_____

Have you ever been diagnosed with alcoholism? ❑ Yes ❑ No

Do you currently drink alcohol regularly? ❑ Yes ❑ No If yes, approx. how many drinks/week (beer, wine, or liquor) _____

Have you ever used intravenous (IV)/Illicit drugs? ❑ Yes ❑ No If yes, please specify _____

FAMILY HISTORY

	Age	Health problems	Cause of death/age at death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Spouse			

NORTH HILLS FAMILY MEDICINE

NEW PATIENT MEDICAL HISTORY FORM

Today's Date: _____

NAME:_____ **DOB:**_____

Please check "X" on the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?).

General	Fatigue / Tired	☐ Yes ☐ No
	Fever / Chills	☐ Yes ☐ No
	Headaches	☐ Yes ☐ No
	Weight loss	☐ Yes ☐ No
	Weight gain	☐ Yes ☐ No
	Insomnia	☐ Yes ☐ No
	Other	_____
Eyes	Blurred vision	☐ Yes ☐ No
	Double vision	☐ Yes ☐ No
	Other	_____
Allergic, Head, Ears, Nose, throat	Runny Nose	☐ Yes ☐ No
	Itchy eyes	☐ Yes ☐ No
	Sore throat	☐ Yes ☐ No
	Hoarseness	☐ Yes ☐ No
	Ear pain	☐ Yes ☐ No
	Hearing issues	☐ Yes ☐ No
	Other	_____
Neuro	Tremors	☐ Yes ☐ No
	Dizzy spells	☐ Yes ☐ No
	Numbness	☐ Yes ☐ No
	Tingling	☐ Yes ☐ No
	Weakness	☐ Yes ☐ No
	Memory Loss	☐ Yes ☐ No
	Other	_____
Gastro-Intestinal	Abdominal pain	☐ Yes ☐ No
	Nausea	☐ Yes ☐ No
	Vomiting	☐ Yes ☐ No
	Diarrhea	☐ Yes ☐ No
	Heartburn	☐ Yes ☐ No
	Trouble swallowing	☐ Yes ☐ No
	Hemorrhoids	☐ Yes ☐ No
	Rectal bleeding	☐ Yes ☐ No
	other	_____
Cardio-Vascular (heart)	Chest pain	☐ Yes ☐ No
	Varicose veins	☐ Yes ☐ No
	Palpitations	☐ Yes ☐ No
	Edema/swelling	☐ Yes ☐ No
	Fainting	☐ Yes ☐ No
	other	_____
Respiratory	Cough	☐ Yes ☐ No
	Shortness of breath	☐ Yes ☐ No
	Use of inhalers	☐ Yes ☐ No
	Wheezing	☐ Yes ☐ No
	Other	_____

Males Only	Blood in urine	☐ Yes ☐ No
	Erectile issue	☐ Yes ☐ No
	Foul odor of urine	☐ Yes ☐ No
	Pain in testicles	☐ Yes ☐ No
	Trouble urinating	☐ Yes ☐ No
	Other	_____
Females Only	Breast discomfort	☐ Yes ☐ No
	Irregular bleeding	☐ Yes ☐ No
	Painful intercourse	☐ Yes ☐ No
	Trouble urinating	☐ Yes ☐ No
	Vaginal discharge	☐ Yes ☐ No
	Other	_____
Musculo-Skeletal	Back pain	☐ Yes ☐ No
	Joint pain	☐ Yes ☐ No
	Muscle pain	☐ Yes ☐ No
	Swelling	☐ Yes ☐ No
	Other	_____
Skin Hair Nails	Bruising	☐ Yes ☐ No
	Hair loss	☐ Yes ☐ No
	Nail problems	☐ Yes ☐ No
	Rash	☐ Yes ☐ No
	Other	_____
Mental health	Anxiety	☐ Yes ☐ No
	Depression	☐ Yes ☐ No
	Trouble sleeping	☐ Yes ☐ No
	Concentration issues	☐ Yes ☐ No
	History of abuse	☐ Yes ☐ No
	Mood swings	☐ Yes ☐ No
	Stress	☐ Yes ☐ No
	Other	☐ Yes ☐ No

Recent Tests / Health Maintenance (month/year)

Bone Density: _____

Colonoscopy:_____

Diabetic Foot Exam: _____

Eye Exam: _____

Mammogram:_____

PAP Smear: _____

Physical: _____

PSA: _____

EKG: _____

Chest X-ray: _____

Tetanus Shot: _____

Pneumonia Shot: _____

NORTH HILLS FAMILY MEDICINE

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

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

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors / facilities in the future.

Please ***print*** patient name	Date of Birth	Please ***sign*** patient name

(If signing for a minor above, please fill out the next line)

Parent or Legal representative	Date	Description of Authority (Mother, Father, etc)

Your comments regarding Acknowledgements or Consents**:** _____

_____

How do you want to be addressed when summoned from the reception area:

❑First Name only ❑Proper Surname ❑Other: _____

Please list any other parties who can have access to your health information:

(This includes step parents, grandparents, spouse, and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office via (Please check all that apply)

❑ Cell phone confirmation ❑ Home phone confirmation ❑ Work phone confirmation
❑ Text message to my cell phone ❑ Email confirmation ❑ Patient Portal
❑ All the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA 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 an 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 Office

NORTH HILLS FAMILY MEDICINE

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I _____ (Name of Parent/Legal Guardian) residing

at _____ (Guardian's address) acknowledge that I

am the lawful parent/guardian of _____ (Name of child) _____ (DOB of child) and that there are no court orders or other documents in effect that would prevent me from conferring the power of consent to another person.

I hereby authorize and appoint the following adults to consent to my child's medical examination and treatment. I give this consent voluntarily in order to make sure that my child receives adequate healthcare. The following adults include:

Name	Relationship	Address	Phone Number

Limitations: Identify any limitations on the kinds of medical services for which authorization is given. If non, state "none." _____

Contact: If the nature of the medical care is not routine, please try to contact me. If you are unable to contact me for any reason, you may rely on the proxy decision-maker for consent. My contact information is: _____.

Signed and dated on: _____

Parent/Legal Guardian: _____ (Signature) _____ (Printed Name)

Witness _____ (Signature) _____ (Printed Name)

Witness: _____ (Signature) _____ (Printed Name)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
North Richland Hills Location

This form will authorize the following party to release medical records as indicated below:

RECORDS REQUESTED FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____ ***By initialing here, you are authorizing the release of your entire chart including the following information:***

HIV Information
Sexually Transmitted Disease (STD) Information
Mental Health Information
Substance Abuse Records
Tobacco/Alcohol Use

_____ Date(s) of service from _____ to _____

_____ Records of care concerning the following condition(s):

_____

RECORDS TO BE SENT TO:

North Hills Family Practice – North Richland Hills Location
4351 Booth Calloway Road, Suite #101
North Richland Hills, TX 76180
Office: 817-284-1165 Fax: 817-590-9721

I understand that my records **WILL NOT** include the individual items listed above unless I initial it is okay to copy/send this information.

Signed: _____
(Patient or person legally authorized to consent on patient's behalf)

_____
Print name of patient Relationship to patient

_____
Patient's Date of Birth

Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
Keller Location

This form will authorize the following party to release medical records as indicated below:

RECORDS REQUESTED FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____ ***By initialing here, you are authorizing the release of your entire chart including the following information:***

HIV Information
Sexually Transmitted Disease (STD) Information
Mental Health Information
Substance Abuse Records
Tobacco/Alcohol Use

_____ Date(s) of service from _____ to _____

_____ Records of care concerning the following condition(s):

_____

RECORDS TO BE SENT TO:

North Hills Family Practice – Keller Location
300 N. Rufe Snow Drive
Keller, TX 76248
Office: 817-431-3800 Fax: 817-431-5232

I understand that my records **WILL NOT** include the individual items listed above unless I initial it is okay to copy/send this information.

Signed: _____

(Patient or person legally authorized to consent on patient's behalf)

_____

Print name of patient Relationship to patient

_____

Patient's Date of Birth

Date: _____

OMNIBUS Rule
HIPAA NOTICE OF PRIVACY PRACTICES

For the Healthcare Facilities of:

North Hills Family Medicine

4351 Booth Calloway Road, Suite 101, North Richland Hills, Texas 76180
Or
300 North Rufe Snow Drive, Keller, Texas 76248

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE HIPAA OMNIBUS RULE OF 2013.

PLEASE REVIEW IT CAREFULLY

For the purposes of this Notice "us" "we" and "our" refers to the Name of this Healthcare Facility: North Hills Family Medicine and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive healthcare services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

The Federal health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, (formerly HIPAA 1996 & HI TECH of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omnibus Rule and state law provide penalties for covered entities, business associates, and their subcontractors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for healthcare services. If you have any questions about this Notice, please ask to speak to our HIPAA Privacy Officer.

Our doctors, clinical staff, employees, Business Associates (outside contractors we hire), their subcontractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker / doctor is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another healthcare provider outside our practice to consult with. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISLOCSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign an Authorization / Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of this one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization / acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization / acknowledgement to provide services before you revoked it).

General Rule – If you do not sign our authorization / acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization / acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization / acknowledgement or revoke it.

Healthcare Treatment, Payment, and Operations Rule.

With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family and others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefit plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide you x-rays because your health plan requires them for payment. Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule

- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you be telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet (we will cover your name just after checking you in), we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our Privacy Officer may review your records to assist you with complaints. If you prefer that we not contact you about appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.
- New HIPAA Omnibus Rule does not require that we provide the above notice regarding Appointment Reminders, Treatment Information or Health Benefits, but we are including these as a courtesy so you understand our business practices with regards to your (PHI) protected health information.

Additionally, you should be made aware of these protection laws on your behalf, under the new HIPAA Omnibus Rule:

- That **Health Insurance Plans** that underwrite cannot use or disclose genetic information for underwriting purposes (this excludes certain long-term care plans). Health Plans that post their NOPP's on their web sites must post these Omnibus Rule changes on their sites by the effective date of the Omnibus Rule, as well as notify you by US Mail by the Omnibus Rules effective date. Plans that do not post their NOPP's on their Web sites must provide you information about Omnibus Rule changes within 60 days of these federal revisions
- **Psychotherapy Notes** maintained by a healthcare provider, must state in their NOPP's that they can allow "use and disclosure" of such notes only with your written authorization

Special Rules

Notwithstanding anything else contained int his Notice, only in accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state, or local law
- When necessary in emergencies to prevent a serious threat to your health and safely or the health and safety of other persons.
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health-care oversight activities (i.e. civil rights law, fraud and abuse investigations, audits, investigations, licensure or permitting, government programs, etc.)

- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directed to locate missing person, identify deceased persons or determine cause of death)
- For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the research will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "de-identified" (i.e. it does not personally identify your name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you are present and verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in your writing withy your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed. As per HIPAA law 164.512(j) (i)…(A) Is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public and (B) is to person or persons reasonably able to prevent or lessen the threat.

Minimum Necessary Rule

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). All of our team members are trained in HIPAA Privacy rules and sign strict Confidentiality Contracts with regards to protecting and keeping private your PHI. So do our Business Associates and their subcontractors. Know that your PHI is protected several layers deep with regards to our business relations. Also, we disclose to others outside our staff, only as much of your PHI as is

necessary to accomplish the recipient's lawful purposes. Still in certain cases, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a consent or Authorization to receive a copy of your records
- To healthcare providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record.
- To the U.S. Department of Health and Human Services (i.e. is connection with a HIPAA complaint)
- To others as required under federal or state law.
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, our Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others to disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule

We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we shred all paper containing PHI, require employees to speak with privacy precautions with discussing PHI with you, we use computer passwords and change them periodically (i.e. when an employee leaves us), we use firewall and router protection to the federal standard, we back up our PHI data off-site and encrypted to federal standard, we do not allow unauthorized access to areas where PHI is stored or filed and/or we have any unsupervised business associates sign Business Associate Confidentiality Agreements).

However, in the event that there is a breach in protecting your PHI, we will follow Federal Guidelines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula to Breach Assessment. Then we will document the situation,

retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the US Department of Health and Human Services at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

Business Associate Rule

Business Associates are defined as: an entity, (non-employee) that in the course of their work will directly / indirectly use, transmit, view, transport, hear, interpret, process or offer PHI for this Facility.

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

Super-Confidential Information Rule

If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Healthcare Treatment, Payment and Operations Rules (see above) without you first signing and properly completing our Consent Form (i.e. you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by Initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (i.e. we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the consent form or the Special Rules authorizing us to do so), we will comply with state and federal law that requires us to warm the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule

We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office and on our website. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule

We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization / Acknowledgement Form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it via a specific Authorization Form, which may be separate from any Authorization / Acknowledgement we may have obtained from you. We will not condition your treatment here on whether you sign the Authorization (or not).

Marketing and Fundraising rules

Limitations on the Disclosure of PHI Regarding Remuneration

The disclosure or sale of your PHI without authorization is prohibited. Under the new HIPAA Omnibus Rule, this would exclude disclosures for public health purposes, for treatment / payment for healthcare, for the sale, transfer, merger, or consolidation of all or part of this facility and for related due diligence, to any of our Business Associates, in connection with the business associate's performance of activities for this facility, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of your PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a prohibited disclosure if the only reimbursement received is "a reasonable, cost-based fee" to cover the cost to prepare and transmit your PHI which would be expressly permitted by law. Notable, under the Omnibus Rule, an authorization to disclose PHI must state that the disclosure will result in remuneration to the Covered Entity. Notwithstanding the changes in the Omnibus Rule, the disclosure of limited data sets (a form of PHI with a number of identifiers removed in accordance with specific HIPAA requirements) for remuneration pursuant to existing agreements is permissible until September 22, 2014, so long as the agreement is not modified within one year before that date.

Limitations on the Use of PHI for Paid Marketing

We will, in accordance with Federal and State Laws, obtain your written authorization to use or disclose your PHI for marketing purposes, (i.e.: to use your photo in ads) but not for activities that constitute treatment or healthcare operations. To clarify, ***Marketing*** is defined by HIPAA's Omnibus Rule, as "a communication about a product or service that encourages recipients…to purchase or use the product or service."

Under Omnibus Rule we will obtain your written authorization prior to using your PHI or making any treatment or healthcare recommendations, should financial remuneration for making the communication be involved from a third party whose product or service we might promote (i.e.: businesses offering this facility incentives to promote their products or services to you). This will also apply to our Business Associate who may receive such remuneration for making a treatment or healthcare recommendations to you. All such recommendations will be limited without your expressed written permission.

We must clarify to you that financial remuneration does not include "as in-kind payments" and payments for a purpose to implement a disease management program. Any promotional gifts of nominal value are not subject to the authorization requirement, and we will abide by the set terms of the law to accept or reject these.

The only exclusion to this would include: “refill reminders”, so long as the remuneration for making such a communication is “reasonably related to our cost” for making such a communication. In accordance with law, this facility and our Business Associates will only ever seek reimbursement from you for permissible costs that include: labor, supplies, and postage. Please note that “generic equivalents”, “adherence to take medication as directed” and “self-administered drug or delivery system communications” are all considered to be “refill reminders”

Face-to-face marketing communications, such as sharing with you, a written product brochure or pamphlet, is permissible under current HIPAA law.

Flexibility on the Use of PHI for Fundraising

Under the HIPAA Omnibus Rule use of PHI is more flexible and does not require your authorization should we choose to include you in any fundraising efforts attempted at this facility. However, we will offer the opportunity for you to “opt out” of receiving future fundraising communications. Simply let us know that you want to “opt out” of such situations. There will be a statement on your ***HIPAA Patient Acknowledgement Form*** where you can choose to “opt out”. Our commitment to care and treat you will in no way effect your decision to participate or not participate in our fundraising efforts.

Improvements to Requirements for Authorizations Related to Research

Under HIPAA Omnibus Rule, we may seek authorizations form you for the use of your PHI for future research. However, we would have to make clear what those uses are in detail.

Also, if we request of you a compound authorization with regards to research this facility would clarify that when a compound authorization is used, and research-related treatment is conditioned upon authorization, the compound authorization will differentiate between the conditioned and unconditioned components.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking our Privacy Officer. Also, you have the following rights regarding PHI we maintain about you:

To Inspect and Copy

You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our Privacy Officer. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our Privacy Officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies on summary of payment of your outstanding balance for professional services if you have one). We will comply with Federal Law to provide your PHI in an electronic

format within the 30 days, to Federal specification, when you provide us with proper written request. Paper copy will also be made available. We will respond to requests in a timely manner, without delay for legal review, or, in less than thirty days if submitted in writing, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI, it came from a confidential source, etc.). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care progression (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed healthcare professional who is not affiliated with us, we will ensure a Business Associate Agreement is executed that prevents re-disclosure of your PHI without your consent by that outside professional.

To Request Amendment / Correction

If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a "**Request for Amendment / Correction"** form to our Privacy Officer. We will act on your request within 30 days from receipt but we may extend our response time (within the 30-day period) no more than once and by no more than 30 days, or as per Federal Law Allowances, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (i.e. it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Resources.

To an Accounting of Disclosures

You may ask us for a list of those who got your PHI from us by submitting a "**Request for Accounting of Disclosures"** form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representatives, given to others for treatment, payment or healthcare operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions

You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set form in this Notice) by submitting a written "**Request for Restrictions on Use, Disclosure"** form to us (i.e. you may not want us to disclose your surgery to family members or friends involve din paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted, you signed an Authorization Form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications

You may ask us to communicate with you in a different way or at a different place by submitting a written "**Request for Alternative Communication"** form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

To Complain or Get More Information

We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Resources
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
877.696.6775

Or, submit a written Complaint form to use at the following address:

Our Privacy Officer:	Beverly Lovell
Office Name:	North Hills Family Medicine
Office Address:	4351 Booth Calloway Road, Suite 101 North Richland Hills, Texas 76180
Office Phone:	817-284-1165
Office Fax:	817-284-4990
Email Address:	Beverlylovell@nhfm.net

You may get your "**HIPAA Complaint"** form by calling our Privacy Officer.

These privacy practices are in accordance with the original HIPAA enforcement effective April 14, 2003, and undated to Omnibus Rule effective March 26, 2013 and will remain in effect until we replace them as specified by Federal and/or State Law.

OPTIONAL RULES FOR NOPP

Faxing and Emailing Rule

When you request us to fax or email your PHI as an alternative communication, we may agree to do so, but only after having our Privacy Officer or treating doctor review that request. For this communication, our Privacy Officer will confirm that the fax number and email address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so that the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message. Our emails are all encrypted per Federal Standard for your protection

Practice Transition Rule

If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing healthcare provider, but only in accordance with the law. The healthcare provider who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice diet, our patient records (including but not limited to your PHI) must be transferred to another healthcare provider within 90 days to comply with State & Federal Laws. Before we transfer records in either of these two situations, our Privacy Officer will obtain a Business Associate Agreement from the purchaser and review your PHI for super-confidential information (i.e. communicable disease records), which will not be transferred without your express written authorization (indicated by your initials on our Consent Form).

Inactive Patient Records

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patient will not be destroyed before the child's eighteenth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

Collections

If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.