Patient Copy to Keep

North Texas Infectious Diseases Consultants, PA

Notice of Privacy Practices

Dear Patient:

This notice is for you to keep and it describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction:

At NTIDC, we are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective September 23, 2013 and applies to all Protected Health Information as defined by federal regulations.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

Understanding Your Medical Record/ Protected Health Information

Each time you visit NTIDC a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication with other health professionals involved in your care.
- Legal documentation outlining and describing the care you received.
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided.
- An education tool for medical health professionals.
- A source for medical research.
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards.
- A source of data for planning and/or marketing.
- A tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how health information is used helps you to ensure its accuracy , determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

How We May Use And/Or Disclose Your Health Information

We May Use Or Disclose Your Health Information:

For Treatment: Your health information may be used by staff members or disclosed to their healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

For Payment: Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you. Note: If you pay out of pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right

to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations and our practice will honor that request.

For Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of NTIDC. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

For Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services: We may use and disclose health information to contact you to remind you that you have an appointment with us. We also may use and disclose health information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

For Business Associates: In some instances, we have contracted separate entitied to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

For Research/Teaching/Training: We may use your information for the purpose of research, teaching, and training. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or discloses Protected Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Protected Health Information.

For Data Breach notification Purposes: We may use or disclose your Protected Health Information to provide legally-required notices of unauthorized access to or disclosure of your health information.

To Coroners, Medical Examiners, and Funeral Directors: We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so they can carry out their duties.

For Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking, or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

For Military and Veterans: If you are a member of the armed forces, we may releases Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

For Workers' Compensation: We may release Health Information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

As Required By Law: We will disclose Protected Health Information when required to do so by international, federal, state or local law.

To Law Enforcement: Your Protected Health Information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

For Public Health Reporting: Your Protected Health Information may be disclosed to public health agencies as required by law.

For Health Oversight Activities: We may disclose your Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

For Abuse, Neglect, or Domestic Violence: We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that decision.

For Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information 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 inform you about the request or to obtain an order protecting the information requested.

For Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Protected Health Information to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the Safety and security of the correctional institution.

To Avert a Serious Threat to Health or Safety: We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Users and Disclosures Where You Have an Opportunity to Object and Opt Out:

For Individuals Involved in Your Care or Payment for Your Care: Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Written Authorization is Required for the Following Uses and Disclosures:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

For Other Uses and Disclosures: Disclosure of your Protected Health Information or its use for any purpose other than those listed above may or may require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not effect or undo any use or disclosure of information that occurred before you notified us of your decision.

OUR RESPONSIBILITES

NTIDC is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/ locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all Protected Health Information that we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according procedures included in the authorization.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to an electronic copy of your medical record(s).
- The right to a summary or explanation of your medical record(s).
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a notice of breach.
- The right to receive a printed copy of this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of NTIDC, please contact: Director of Clinical Services
North Texas Infectious Diseases Consultants
North Texas Infusion Centers
3409 Worth Street, Ste. 710
Dallas, Texas 75246
214 823-2533

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Officer, or, you may file a complaint with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Officer or with the Office for Civil Rights.

To file a complaint with the OCR, you may:

(1) Mail it to:
Secretary of the U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201;
(2) Call (202) 619-0257 (or toll free (877-696-6775);
(3) Or visit the OCR website, www.hhs.gov/ocr/hipaa/, for more information on the options listed above, or for electronic filing options.

Patient Copy to Keep

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS
PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

- Have reasonable access to care, receiving treatment and medical services in a safe environment and without discrimination based on age, race, ethnicity, nationality, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation or preference, or gender identity or expression.
- Be treated with dignity, courtesy, consideration and respect.
- Participate in the development and implementation of his/her plan of care, if able.
- Be informed of their medical condition, recommended treatments, expected results, risks involved and reasonable medical alternatives.
- Receive information in a manner he/she understands and to be provided with services of a translator or interpreter, if necessary.
- Expect quality care and treatment.
- Be informed of opportunities for involvement in research projects, as they apply.
- Receive the appropriate assessment and management of pain.
- Make informed decisions regarding care and to refuse medication or treatment after possible consequences of this decision have been explained clearly.
- Give informed, written consent (if required by applicable law) prior to the start of specified, non-emergency medical procedures or treatments.
- Expect personal privacy and confidentiality of medical information as required by law.
- Be advised of the approximate costs related to his/her medical care and receive advice about financial assistance or payment plans.
- Receive a detailed bill that describes charges for professional fees, products, and equipment used during their therapy.
- Be informed of the names and functions of healthcare professionals providing personal care and the right of choice in the care provided.
- Be free from neglect; exploitation; verbal, mental, physical, and sexual abuses, and harassment.
- Receive answers to questions, regarding emergent issues, 24 hours a day, 7 days a week.
- To file a complaint or to recommend changes in policies or services to the company without fear of coercion, discrimination, reprisal, or service interruption.
- Obtain a copy of his/her medical records at a reasonable fee and within a reasonable time frame after submitting a written request to Medical Records.

Patient Privacy or Confidentiality Complaints: 214 276-5639

Billing Concerns: 214 276-5656

Patients have the responsibility to:

- Provide information about their health and medical history, including past illnesses, hospital stays, and use of medications.
- Inform their health care provider if special accommodations are needed to assist their understanding of the treatment plan.
- Ask questions or acknowledge when they are not clear about information provided or do not understand the treatment course or care decision.
- Accept consequences if they do not follow the recommended treatment plan; recognize the effect of lifestyle choices on their health.
- Follow facility rules and regulations, and be respectful and considerate of other patients, staff and property, which includes not recording (by photography, video, audio or other means) other patients, physicians, or staff without prior permission, and maintaining civil language and conduct.
- Meet financial obligations associated with their care.
- Advise their health care provider or office personnel of any dissatisfaction regarding their care.

North Texas Infectious Diseases Consultants takes a strong position on reporting issues and concerns related to such things as patient quality of care, safety, privacy and ethical concerns. Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services by letter or phone at the contact numbers and addresses listed below.

Texas Department of State Health Services at
(888) 973-0022 (toll free number).
1100 W. 49th Street
Austin, Texas 78756-3199

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA

Consent for Treatment

I, as a patient/legal guardian, do consent for medical treatment by North Texas Infectious Diseases Consultants' (NTIDC) physicians and physician assistants, this is inclusive of any treatment or procedure they deem medically necessary.

_____ _____

Patient/Guardian Signature Date

Authorization to Release Medical Information

This is to serve as authorization to release medical information compiled in the course of medical treatment at NTIDC to the undersigned patient. A copy of this will serve as an original.

_____ _____

Patient/Guardian Signature Date

Acknowledgement of Receiving and Reading a Copy of, "Notice of Privacy Practices" and "Patient Rights and Responsibilities"

I acknowledge receipt of NTIDC's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how NTIDC may use and disclose by confidential information. I understand that NTIDC reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

_____ _____

Patient/Guardian Signature Date

Physician Assistant Consent for Treatment

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

I have read the above, and hereby consent to the services of a physician assistant for my health care needs**. I understand that at any time I can refuse to see the physician assistant and request to see a physician.**

_____ _____

Print Patient Name Date of Birth Patient's Signature Date

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A.

Check Provider:

___Berhe ___Bettacchi ___Columbus ___Haley ___Sloan ___Spak ___Duhaime

If you are a member of an HMO/PPO, and they require prior authorization numbers, you must provide the number prior to service. **If the necessary numbers are not provided, you will be financially responsible for unauthorized services.**

Your Name: _____ Birthdate: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M or F Race: _____ Ethnicity: Latin/Hispanic, Other, Not Reported

Marital Status: _____ SS# _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax: _____ Best way to reach you: Home Cell Work

Circle One

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician _____ Phone: _____

Spouse: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ hm / cell / wk

Circle One

Emergency Contact: _____ Relation: _____ Phone: _____ hm /cell / wk

may put same if spouse *Circle One*

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PRIMARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

SECONDARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

PLEASE COMPLETE THE BACK OF THIS FORM

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA

Patient Consent for Use and Disclosure of Protected Health Information

North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St., Sammons Tower, Suite 710, Dallas, Texas, 75246.

You may disclose protected health information (PHI) about me to the friends and family **LISTED** below:

1._____ 2._____ 3._____ **Initials** _____

4._____ 5._____ 6._____ **N/A** _____

With my consent, NTIDC may contact me regarding a possible research study.

Initials _____

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC 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.

Email Address: _____N/A_____ Initials _____

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to prior consent.

_____ _____

Print Patient's Name Date of Birth Patient's Signature Date

_____ _____

Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian

How were you referred to our office? ___Personal Physician ___Internet ___Friend/Family ___Newspaper ___Seen in the hospital ___other

PLEASE COMPLETE THE BACK OF THIS FORM

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A.
CONFIDENTIAL PATIENT HISTORY

Name: _____ Date of Birth: _____ M F SEX Today's Date: _____

Drug Allergies (please list all)	**Drug Reaction (e.g., rash, nausea, etc.)**

Allergic/Immunologic: (please list all other allergies):

Past Medical History
(please check all that apply)

- Blood Disorders ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Lung Disease ☐
- Diabetes ☐
- Peptic Ulcer Disease ☐
- Cancer ☐
- Liver Disease ☐
- Psychiatric Disorder ☐
- Other (please list below) ☐

Past Hospitalizations

Reason for Hospitalization	***Dates***

Past Surgical History

Reason for Surgery	***Dates***

Past Transfusions

	Date

Social History

Marital Status:	☐ Married	☐ Divorced	☐ Single
Tobacco Use:	☐ Yes	☐ No	How Much? _____
Alcohol Use:	☐ Yes	☐ No	How Much? _____
Drug Use:	☐ Yes	☐ No	How Much? _____

Occupation: _____

Please complete information on back of this form ⇨⇨⇨⇨

Patient Name: Date of Birth:

Family History

Please list any significant or serious illnesses in your family:

Review of Systems ***(please circle all which are applicable)*** **:**

Constitutional: Weight loss Weight gain Fever Chills Sweats Fatigue Weakness

Eyes: Wear glasses Blurry vision Flashing lights Blindness

Ears, Nose, Mouth: Ear ache Poor hearing Sore throat

Cardiovascular: Chest Pain Palpitations Swelling of feet

Respiratory: Shortness of breath Cough Asthma

Gastrointestinal: Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool

Genitourinary: Painful urination Frequent urination Nighttime urination
Problems w/testicles
Abnormal periods Last normal menstrual period: _____
DATE

Musculoskeletal: Muscle pain Joint pain

Skin: Rash Sores on skin Skin cancer Boils

Neurological: Headache Dizziness Seizures Numbness Tingling

Heme/Lymphatic: Swollen lymph glands Anemia

What problem do you have today? _____

Do you have other symptoms? (please list) _____

Do you have a Living Will? ☐ Yes ☐ No

If "Yes", what are the contents?

☐ No Resuscitation
☐ No Feeding Tubes
☐ No Medication Support
☐ No Mechanical Ventilation
☐ Unaware of Contents
☐ Other _____

Do you have a Durable Power of Attorney? ☐ Yes ☐ No **Name:** _____

North Texas Infectious Diseases Consultants, P.A.
Universal Medication List

(Include all herbals, prescription, and non-prescription medications, supplements, eye drops, patches, inhaler, etc.)

Information provided by: Patient Family Friend Other:_____

Unable to attain due to: Patient condition Patient's lack of knowledge of medications

Allergies: _____ Latex Tape Iodine

Patient Name: _____ Patient date of birth: _____

Pharmacy Name: _____ Pharmacy Phone # : _____

Physician Instructions		Drug Name and Dose (Avoid abbreviations of any kind)	Route		Frequency (Avoid abbreviations)	Last Taken date/time	Nurse Initials	
Continue	Do Not Take		By Mouth ✔	Other (i.e. patch, rectal, etc.)			Approximate Date Started	Prescribing Physician
		Example: Biaxin 500 milligrams	✔		2 daily	today / 8am	3/07	Jones

The listed medications are correct. I understand if prescriptions are to be filled, I will do this at the pharmacy of my choice ***Do not take any other medication not listed on this sheet.***

Signature of Patient or Authorized Representative Date

Signature of Nurse Reviewing Medication List Date