PATIENT INFORMATION

OFFICE USE ONLY – INS _____%_____CP PAT _____ APV ____ ____/____/____

PATIENT LAST NAME: FIRST: MIDDLE:

Race (check box)	Ethnicity (check box)	Marital Status (check box)	Preferred Language (check box)	Date of Birth / /
❑ White ❑ Black/African American ❑ Asian ❑ American Indian ❑ Native Hawaiian ❑ Other _____	❑ Non-Hispanic White ❑ Hispanic/Latino ❑ African American ❑ Asian ❑ Other _____	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow	❑ English ❑ Spanish ❑ Other _____	❑ Male ❑ Female

Home Address:
City, State, Zip:

Email Address:

Social Security Number:

Home phone : ( ) Cell phone: ( ) Work phone: ( )

Person responsible for bill: Relationship to patient:

Emergency Contact: Relationship to patient: Home phone: Work phone:

INSURANCE INFORMATION

Primary Insurance Name:	Secondary Insurance Name:
Policy#: Group#	Policy#: Group#
Subscriber Name:	Subscriber Name:
Subscriber S.S. #	Subscriber S.S. #
Subscriber Date of Birth:	Subscriber Date of Birth:
Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

POLICIES AND ACKNOWLEDGEMENTS

Assignment of Benefits: I hereby assign to Seguin Family Medicine any insurance or other third-party benefits available for health care services provided to me. I understand that Seguin Family Medicine has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Seguin Family Medicine, I agree to forward to Seguin Family Medicine all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Payment Policy: All services rendered are the financial responsibility of the patient or the patient's parent or guardian at the time services are rendered. The patient is responsible for payment regardless of insurance coverage. Billing information should be provided to expedite payment from insurance carriers. Delinquent accounts are subject to 36% of balance for collections if account is referred to outside agency. I hereby authorize the provider of services (Dr. Talbot) to release information concerning my examination and/or treatment for insurance purposes and I also authorize direct payment to Nicole Talbot D.O. for benefits payable from my insurance company.

No Show Policy: To better serve all of our patients, our office has adopted a **"NO SHOW POLICY'**. An appointment is considered a **"NO SHOW"** appointment if the patient fails to cancel the appointment at least **24 hours** in **advance**. Should you fail to keep your scheduled appointment, you will be charged a **$25.00** fee. In addition, after (2) two "No Show" appointments within (1) one calendar year, it is with our regret, that the patient will be terminated from our practice.

Acknowledgement of Review of "Notice of Privacy Practices": I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Disclosure to Families and Loved Ones: This office honors the important role that families, friends, and other loved ones play in supporting our patients' health care and treatment. At the same time, we are committed to protecting our patients' privacy as well as complying with state and federal law. Accordingly, disclosure to other people, even family, must remain a decision that rests with the patient. To the extent that is possible, we will follow the alternatives given in this policy.

CHECK ALL THAT APPLY

- ☐ **It is acceptable for you to leave information on my answering machine, including appointment reminder**
- ☐ **I do not want you to speak with any family members or friends regarding my condition.**
- ☐ **It is acceptable for you to speak with only the following family members/friends regarding my condition**

1._____ 2._____ 3._____

*It is the patient's responsibility to notify the office staff of any changes to this Authorization.

The above information is true to the best of my knowledge. I have reviewed the above policies and do hereby agree with the terms and policies of Seguin Family Medicine.

Patient/GuardianSignature_____ Date_____

SEGUIN FAMILY MEDICINE

PATIENT PORTAL AUTHORIZATION AGREEMENT

Name: _____

Email: _____

(Please print clearly)

Purpose of this Form

Seguin Family Medicine offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate

You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal through our website at www.seguinfamilymedicine.com or directly by going to www.gotomyclinic.com/seguinfamilymedicine.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Seguin Family Medicine or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. If you have questions we will gladly provide more information.

Patient Acknowledgement

_____ _____

Patient Signature **Date**

For Office Use Only I have authenticated the identity of the person named on this authorization form:

☐ Picture ID ☐ Person known to me ☐ Other:_____ Employee Signature _____Date

SEGUIN FAMILY MEDICINE **NARCOTIC AGREEMENT**

This agreement is between patient and Seguin Family Medicine (SFM). It is agreed that narcotic medication will be given by Dr. Nicole Talbot on a regular basis to patient **only** if the following terms are met:

1. By signing a contract for narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including side effects, and is agreeable to start this treatment under the terms set by SFM.
2. The patient has the chance to ask questions regarding alternatives to the use of narcotic medications.
3. SFM should be the **one and only source** of narcotic medications unless written permission is given by SFM physician for the patient to get narcotic prescriptions from another physician.
4. **Only ONE pharmacy will be used for filling narcotic prescriptions.**
   The name of pharmacy: _____
   Pharmacy phone number: _____
5. If it is found that the patient received prescriptions for narcotic medications from a source other than the SFM physician, without written permission, SFM may void this agreement and discontinue any prescriptions of narcotic medications to the patient.
6. The patient agrees to have **urine tests** for medications done randomly at the physician's request.
7. The patient must agree to allow the SFM physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.
8. The patient must supply documentation of treatment by other physician for co-existing, or related condition, including psychiatric conditions.
9. The patient understands that SFM will not replace any lost or inaccessible narcotic prescriptions or narcotic medications, for **ANY REASON.**
10. The patient must take the narcotic medications **exactly as instructed** by the SFM Physician.
11. Any unauthorized increase in the dose of narcotic medication may be viewed as a cause for discontinuation of the treatment with narcotic medications.
12. If the patient demonstrates unacceptable behavior patterns, the SFM physician may discontinue prescribing the narcotic medications for the patient.
13. The patient must **keep all regular follow up appointments** as recommended by the SFM physicians. Failure to comply may cause discontinuation of narcotic prescriptions.
14. The patient must comply with **all** aspects of the treatment plan, including, but not limited to, Physical Therapy, Behavioral Management, and self-help programs.
15. All prescriptions must be picked up by the patient himself/herself. If the patient is too debilitated or sick, an exception may be allowed.
16. **No narcotic prescriptions will be refilled on weekends or over the phone.**
17. **Narcotic prescriptions WILL NOT be refilled early.**
18. The patient understands that the benefit of the narcotic medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of rehabilitation program, return to work, maintenance of job, etc.
19. The patient understands the narcotic medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.
20. The patient certifies or agrees to the following:

a) That he/she is **not currently abusing illicit** or prescription drugs.
b) That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substance (narcotics, sleeping pills, nerve pills, or pain killers).
c) That she is not pregnant and that she will use appropriate contraception during her course of treatment.
d) **Sharing your narcotics is strictly prohibited**. Any sharing will result in immediate cancellation of your prescription refills.

21. Evidence of medication hoarding, increasing the amount of medication without communication to your SFM physician, refilling your prescription too frequently, getting the medication from multiple physicians, increasing the amount of medication despite significant side effects, altering prescription, medication sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription, medications inconsistent with drug labeling) during narcotic analgesic treatment or other unacceptable behavior will result in tapering and discontinuing of narcotic therapy.
22. **If the patient is non-compliant or un-cooperative with the Physician or Office Staff we reserve the right to discharge you at any time.**

I fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in treatment of my pain problem. This for has been fully explained to me, I have read it or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

Date: _____
Patient Signature: _____
Patient Printed Name: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE THE PROVIDER BELOW TO RELEASE MY MEDICAL RECORDS :

Provider: (name and address)	Patient: SS#: DOB:

✓***Check all that apply*** *RECORDS AUTHORIZED TO BE RELEASED:*

____ All Medical Records	____ Health summary
____ X-ray/radiology records	____ Pharmacy/prescription records
____ Laboratory/pathology reports	____ Billing records
____ Psychiatric/mental health records	____ Drug/alcohol use/abuse
____ HIV (AIDS) test results/information	____ Other (specify):_____

***Note:** When "All Medical Record" status is selected, you are hereby authorizing disclosure any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease*

THESE MEDICAL RECORDS WILL BE USED FOR THE PURPOSE OF:

____ Continuing care	____ Personal copy	____ Insurance claim
____ Legal claim	____ Disability determination	____ Other _____

I AUTHORIZE MY MEDICAL RECORDS TO BE DISCLOSED AND USED BY THE FOLLOWING ORGANIZATION:

SEGUIN FAMILY MEDICINE
515 N. King Street, Suite 103
Seguin, Texas 78155
Phone: 830-372-5200 Fax: 830-372-5202

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. *I also understand that:*

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Seguin Family Medicine may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as the original.

Patient or Representative Signature _____

Patient or Representative (printed) _____

Relationship to Patient _____

Date _____

Review of Systems Check all that apply to you, current past conditions.

Symptom / Condition	Date Diagnosed
Eyes	
☐ Itching	
☐ Burning	
☐ Mattering	
☐ Loss of Vision	
☐ Other	
☐ Constitutional	
Developmental Disorders	
☐ Cancer	
☐ Fatigue Syndrome	
☐ Other	
Ear, Nose, Mouth, Throat	
☐ Sinusitis	
☐ Dry Mouth	
☐ Hearing Loss	
☐ Laryngitis	
☐ Other	
Neurological - Nervous System	
☐ Epilepsy	
☐ Multiple Seizures	
☐ Tumor	
☐ Cerebral Palsy	
☐ Stroke/CVA	
☐ Migraine	
☐ Other	
Psychiatric	
☐ Depression	
☐ Bipolar	
☐ Anxiety	
☐ Attention Deficit	
☐ Other	
Vascular/Cardiovascular	
☐ Vascular Disease	
☐ Stroke	
☐ Heart Disease	
☐ High Blood Pressure	
☐ Congestive Heart Failure	
☐ Other	
Respiratory	
☐ Cigarette Smoker	
☐ Bronchitis	
☐ COPD	
☐ Emphysema	
☐ Asthma	
☐ Sleep Apnea	
☐ Other	

Symptom / Condition	Date Diagnosed
Gastrointestinal [Stomach and Intestines]	
☐ Celiac Disease	
☐ Crohn's Disease	
☐ Ulcer	
☐ Colitis	
☐ Acid Reflux	
☐ Other	
Genitourinary [Genital and Urinary organs]	
☐ Kidney Disease	
☐ STD – Herpetic/Chlamydia	
☐ Prostate Disease/Cancer	
☐ Pregnant/Nursing	
☐ Other	
Musculoskeletal [Muscles, Bones, and Joints]	
☐ Arthritis	
☐ Ankylosing Spondylitis	
☐ Fibromyalgia	
☐ Muscular Dystrophy	
☐ Osteoarthritis	
☐ Gout	
☐ Other	
Integumentary [Hair, Skin and Nails]	
☐ Herpes Simplex/Cold Sores	
☐ Herpes Zoster/Shingles	
☐ Rosacea	
☐ Psoriasis	
☐ Eczema	
☐ Other	
Endocrine [Thyroid, Pancreas]	
☐ Diabetes Type II	
☐ Hypothyroidism	
☐ Hyperthyroidism	
☐ Hormonal Dysfunction	
☐ Diabetes Type I	
☐ Other	
Hematologic/Lymphatic [Blood and lymph]	
☐ Large Volume Blood Loss	
☐ Anemia	
☐ Ulcer	
☐ High Cholesterol	
☐ Other	
Allergic/Immunologic	
☐ Environmental Allergies	
☐ Lupus	
☐ Rheumatoid Arthritis	
☐ Drug Allergies	
☐ Other	

SEGUIN FAMILY MEDICINE HEALTH HISTORY QUESTIONNAIRE OFFICE USE ONLY –PAT ____ APV _____ ____/____/____

ATIENT LAST NAME:	FIRST:	MIDDLE:

DATE OF BIRTH: / /	AGE:	Gender: ☐ M ☐ F	☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Partnered

OCCUPATION:	EMPLOYER:

REASON FOR TODAY'S VISIT

	Brief Description		Brief Description		Brief Description
☐ Skin		☐ Chest/Heart		☐ Weight	
☐ Head/Neck		☐ Back		☐ Energy	
☐ Ears		☐ Intestinal		☐ Sleep	
☐ Nose		☐ Bladder		☐ other	
☐ Throat		☐ Bowel		☐ other	

OTHER PROVIDERS

	Name of Provider		Name of Provider		Name of Provider
☐ Cardiologist		☐ Internist		☐ Pain Specialist	
☐ Dermatologist		☐ Nephrologist		☐ Psychiatrist	
☐ E/N/T		☐ Neurologist		☐ Pulmonologist	
☐ Gastroenterologist		☐ OB-GYN		☐ Rheumatologist	
☐ Hematologist		☐ Oncologist		☐ Other	
☐ Infectious Disease		☐ Orthopedist		☐ Other	

PERSONAL HEALTH HISTORY

Childhood Illness	Date	Immunizations	Date	Preventive Care	Date
☐ Measles		☐ Tetanus		☐ Routine Exam	
☐ Mumps		☐ Hepatitis		☐ Colonoscopy	
☐ Rubella		☐ Influenza		☐ Bone Density	
☐ Chickenpox		☐ Pneumonia		☐ Vision Exam	
☐ Rheumatic Fever		☐ Chickenpox		☐ Hearing Exam	
☐Polio		☐ MMR		☐ Other	

MEN ONLY

	DATE
☐ Testicular Exam	
☐ Prostate Exam	

WOMEN ONLY

	DATE
☐ Mammogram	
☐ Pap Smear	
☐ Rectal Exam	

Date of last menstruation:			
Heavy periods, irregularity, spotting, pain, or discharge?	☐Y ☐N		
Number of pregnancies		Number of live births	
Are you pregnant or breastfeeding?	☐Y ☐N		
Have you had a D&C, hysterectomy, or Cesarean?	☐Y ☐N		
Current Birth Control Method:			
Age of menopause:			

LIST PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Drug Name	Strength	Dosage	Drug Name	Strength	Dosage

LIST ANY ALLERGIES TO MEDICATIONS	
Name of Drug	Reaction you had

SURGERIES/COSMETIC PROCEDURES		
Year	Reason	Hospital

OTHER HOSPITALIZATIONS		
Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ Yes	☐ No

HEALTH HABITS AND PERSONAL SAFETY					
CAFFEINE	# per day	ALCOHOL	TOBACCO	# per day	RECREATIONAL DRUGS
☐ None		☐ None	☐ Non-smoker		☐ None
☐ Coffee		☐ Yes, I consume alcohol	☐ Cigarettes		☐ Currently Use
☐ Tea		If yes, what kind?	☐ Chew		☐ Prior Use
☐ Cola		How many drinks per week?	☐ Pipe		Type _____
		Are you concerned about the amount you drink? ☐Y ☐N	☐ Electronic		Have you ever given yourself street drugs with a needle? ☐Y ☐N

FAMILY HEALTH HISTORY			
FAMILY MEMBER	AGE	DECEASED	LIST SIGNIFICANT HEALTH PROBLEMS
Father		☐Y ☐N	
Mother		☐Y ☐N	
Sibling ☐ F ☐ M		☐Y ☐N	
Sibling ☐ F ☐ M		☐Y ☐N	
Sibling ☐ F ☐ M		☐Y ☐N	
Sibling ☐ F ☐ M		☐Y ☐N	
Grandfather -maternal		☐Y ☐N	
Grandmother - maternal		☐Y ☐N	
Grandfather - paternal		☐Y ☐N	
Grandmother - paternal		☐Y ☐N	
Child ☐ F ☐ M		☐Y ☐N	
Child ☐ F ☐ M		☐Y ☐N	
Child ☐ F ☐ M		☐Y ☐N	
Chile ☐ F ☐ M		☐Y ☐N	

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.
Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.
We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.
If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.
Workers' Compensation We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law
The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.
You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.
To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.
We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.
We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.
Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.
HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

PLEASE KEEP THIS NOTICE FOR YOUR RECORDS

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.
If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.
Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.
D. Appointment Reminders, Treatment Alternatives, and Other Benefits
We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.
E. Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.
F. Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.
F. Questions and Contact Person for Requests
If you have questions or want to make a request pursuant to the rights described above, please contact:
Heather Doche
Office Manager
515 N King Street, Suite 103
Seguin, TX 78155
Phone: (830) 372-5204
Fax: (830) 372-5202
om@seguinfamilymedicine.com

NOTICE: The Office of the General Counsel of the Texas Medical Association provides this information with the express understanding that 1) no attorney-client relationship exist, 2) neither TMA nor its

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

This document is meant to inform our patients of their rights and responsibilities while undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

Access to Care. You will be provided with impartial access to treatment and services within this practice's capacity, availability, and applicable law and regulation. This is regardless of race, creed, sex, national origin, religion, disability/handicap, or source of payment for care/services.

Respect and Dignity. You have the right to considerate, respectful care/services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

Privacy and Confidentiality. You have the right, within the law, to personal and informational privacy. This includes the right to:

- Be interviewed and examined in surroundings that assure reasonable privacy.
- Have a person of your own sex present during physical examination or treatment.
- Not remain disrobed any longer than is required for accomplishing treatment/services.
- Request transfer to another treatment room if a visitor is unreasonably disturbing.
- Expect that any discussion or consultation regarding care will be conducted discreetly.
- Expect all written communications pertaining to care will be treated as confidential.
- Expect medical records to be read only by individuals directly involved in care, quality assurance activities, or processing of insurance claims. No other persons will have access without your written authorization.

Personal Safety. You have the right to expect reasonable safety insofar as the office practices and environment are concerned.

Identity. You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for care.

Information. You have the right to obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms that you understand.

Communication. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

Consent. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.

- Consent discussions will include explanation of the condition, risks and benefits of treatment, as well as consequences of no treatment.
- You will not be subjected to any procedure without providing voluntary, written consent.
- You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

Consultation. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

Charges. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

Rules and Regulations. You will be informed of practice rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

Keep Us Accurately Informed. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

Follow Your Treatment Plan. You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the physician's orders and as they enforce the applicable practice rules and regulations.

Keep Your Appointments. You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.

Take Responsibility for Noncompliance. You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

Be Responsible for Your Financial Obligations. You are responsible for assuring that the financial obligations of health care services are fulfilled as promptly as possible, and for providing up-to-date insurance information.

Be Considerate of Others. You are responsible for being considerate of the rights of other patients and personnel, and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

Be Responsible for Lifestyle Choices. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

PLEASE KEEP THIS NOTICE FOR YOUR RECORDS