REGISTRATION INFORMATION

DEMOGRAPHIC INFORMATION

Date

Last Name First Name Preferred Name

DOB Gender

Primary Phone Number Alternate Phone Number

Primary Email Address

Mailing Address

Emergency Contact Name Emergency Contact Phone

Emergency Contact Email Emergency Contact Relation

MEDICAL HISTORY

Please list any drug allergies:

Please note if you have ever been diagnosed with the following:

High Blood Pressure ☐	Diabetes ☐	High Cholesterol ☐
Heart Rhythm Problems☐	Heart Failure ☐	Asthma ☐
COPD ☐	Thyroid Problems ☐	Sleep Apnea ☐
Sleep Disorder	Cancer (please list type) ☐	

Please list any other medical diagnoses that have been made in the past:

Please list all surgeries you have had in the past:

Please list any specialists you see regularly, or who may prescribe medication to you:

Please list all prescription medications (you may also attach a list):

Please check if you have had the following, and enter the approximate date:

☐ Colonscopy

☐ Mammogram

☐ Bone Density

☐ Papsmear

☐ Lung Cancer Screening

☐ Echocardiogram

☐ Stress Test

☐ Heart Saver/Heart Calcium Scan

Please check if you have had the following, and enter the approximate date:

☐ COVID vaccine

☐ Tetanus/Diptheria/Pertussis vaccine

☐ Shingles vaccine

☐ Pneumonia vaccine

☐ Gardasil (HPV) vaccine

List dates and location of any recent ER visits or hospitalizations:

When was your last complete physical exam with blood work:

Females Only:

How many times (if ever) have you been pregnant?

How many live babies were born?

Are you on birth control? What type?

When was your last menstrual period?

FAMILY HISTORY

List any family members who have had the following:

Heart Attacks

Strokes

Cancer – please list type

Diabetes

Other

SOCIAL HISTORY

Do you currently smoke?☐ If so, how many cigs/week? When did you start smoking?

If you previously smoked, how many years did you smoke? When did you quit?

Do you currently drink? ☐ If so, how many drinks/week?

Do you currently exercise? ☐ If so, how many days a week?

Are you: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Occupation/Employer:

How did you find our office:

HEALTH INSURANCE PRIVACY AND ACCOUNTABILITY ACT (HIPAA) CONSENT

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.

A. **How This Medical Practice May Use or Disclose Your Health Information** This medical practice collects health information about you and stores it in a chart [and on a computer] [and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient--safety activities, their population--based efforts to improve health or reduce health care costs, their protocol development, case management or care--coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during audits, investigations, inspections, licensure and other

proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information during any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Worker's Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. If this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]
22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will

stop using or disclosing these notes.

B. **When This Medical Practice May Not Use or Disclose Your Health Information** Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. **Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent

disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or
law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. **Changes to this Notice of Privacy Practices:** We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add*: We will also post the current notice on our website.]

E. **Complaints:** Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our owner, Aline C. Zeringue, APRN, ACNS-BC.

If you are not satisfied with the way this office handles a complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services.

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Further information about privacy rights may be found at
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

As required by the HIPPA Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of Notice of Privacy Practice and understand my rights contained in the notice.

DISCLAIMER: By typing your name below, you are signing this document electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Name:

Date Signed:

2004 Old Granger Rd Taylor, TX 76574 Office (512) 856-5551 Fax (512) 615-5188 www.ttxprimarycare.com

TTX PRIMARY CARE PRACTICE POLICIES

Services Provided

TTX Primary Care employs licensed health care providers to provide diagnosis and management for adults in accordance with Texas laws. Following an initial assessment, discussion of treatment options and recommendations will occur. Together, a decision on the best course of action will be made. Primary care is a partnership and requires active participation from both patients and providers.

Insurance / Financial Agreement

TTX Primary Care and its providers to not contract with commercial insurance plans. TTX Primary Care is not contracted with Medicaid or any Medicare Advantage Plans. Payment is due at the time services are rendered and is based on the fees outlined prior to starting treatment. For patients with insurance, TTX Primary Care and its providers are considered "out-of-network". A billing statement will be available for patients at the completion of the visit. Patients may choose to submit this statement to health insurance carriers to receive reimbursement at "out-of-network" rates. Outside of providing the billing statement and the visit documentation notes with appropriate diagnosis codes, we do NOT participate in the re-imbursement process and will not submit claims directly to insurance carriers.

We are considered in-network with "traditional" Medicare. As a service to those patients with traditional Medicare, we will bill Medicare directly. We will collect any co-pays at the time of the visit or bill for those co-pays. Patients are still responsible for any co-pays, any co-insurance, and meeting all required deductibles and out of pocket expenses per the terms of Medicare.

There will be a $40 fee for any returned check.

Prescription Refills

Prescriptions will be sent electronically to the pharmacy. If refills are needed, patients should first contact the pharmacy to request a refill. If there are no further refills available on a medication, patients should call the office. Patients should allow 48-72 hours for refill requests to be processed and should request these during normal business hours, Monday – Thursday, 7:30-5:30.

Prescription of Controlled Medications

TTX Primary Care does not prescribe ANY schedule II drugs, including opioids or stimulants, or medical cannabis. Prior to initiation or continuation of any controlled medications, such as opiate derivatives, benzodiazepines, hypnotics and other controlled substances, Federal and State databases (Prescription Monitoring Program) will be accessed and routinely monitored.

Patients who require chronic pain medication will be referred to a pain medicine specialist.

Patients with chronic psychiatric illnesses may be referred to our psychiatric, psychologist, or therapy specialist colleagues.

Prescription medication forgery, misuse and/or diversion of controlled medications are grounds for termination from the practice.

Cancellations, No-Shows, and Late Arrivals

TTX Primary Care understands the complexities of life and unforeseen changes that may occur. Patients are asked to kindly give 24-hour notice if they are unable to make a scheduled appointment. Patients arriving late to scheduled appointment times may be asked to wait or reschedule.

Emergencies and After-Hours

In the event of a medical emergency, patients should call 911 or go to the nearest emergency department. Currently, TTX Primary Care does not provide after-hours access or services. Patients should contact the office during normal business hours, Monday – Thursday, 7:30-5:30.

Treatment of Staff

TTX Primary Care has a zero-tolerance policy for any disrespect, rudeness or abusive behavior toward staff or employees. Behavior as such will result in immediate termination from the practice.

Communication by Telephone

There are times we will need to communicate with you by telephone. If you are not immediately available at those times, we will need permission to leave detailed messages on your primary phone concerning your care. Please indicate your preferences below so we are clear about your wishes on this matter.

☐ You MAY leave a voicemail with confidential information regarding non-urgent medical issues.

☐ You MAY NOT leave a voicemail with confidential information regarding non-urgent medical issues.

Medical and Financial Consent – Signature Required

TTX Primary Care employs licensed health care providers to provide diagnosis and management for adults in accordance with Texas laws. I authorize the providers at TTX Primary Care to provide me with reasonable and proper medical care.

I understand that I am financially responsible for all charges that are due at the time services are rendered. I understand that TTX Primary Care, unless I have traditional Medicare, will NOT file charges with my insurance company. I am fully responsible for submitting and collecting on any charges or claims that may be reimbursed by my insurance company.

I have read a copy of the practice policies outlined above. I have been given an opportunity to ask questions and understand the policies as they are described.

DISCLAIMER: By typing your name below, you are signing this document electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Name:

Date Signed: