DEAR PATIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REIVEW IT CAREFULLY.

## INTRODUCTION

At North Tarrant Family Practice, 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 April 14, 2003 and applies to all protected health information as defined by federal regulations.

## UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit North Tarrant Family Practice, 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 document outlining and describing the care you received
- A tool that you or another payer (i.e. insurance company) will use to verify that services billed were actually provided.
- An education tool for medical health providers
- 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.

## YOUR RIGHTS

You have certain rights under the federal privacy standards. They 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 amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected information has been disclosed
- The right to receive a printed copy of this notice

## OUR RESPONSIBLITIES

North Tarrant Family Practice 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 at 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 to procedures included in the authorization.

## HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

**We will use your health information for treatment**. Your health information may be used by staff members or disclosed to other health care 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.

**We will use your information for payment.** Your health plan may request and receive information on dates of service, the service provided, and the medical condition being treated in order to pay for the service rendered to you.

**We will use your information for regular health operations.** Your health information may be used as necessary to support the day-to-day activities and management of North Tarrant Family Practice. For Example: information on the services that you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Business Associates**. In some instances, we have contracted separate entities to provide

services for us. These “associates" require your health information in order to accomplish the tasks that we have asked them to provide. Some examples of these “business associates” might be a billing service, collection agency, answering service, and computer software/ hardware provider.

**Communication with Family**. 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 this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

**Research/Teaching/Training:**
We may use your information for the purpose of research, teaching and training.

**Healthcare Oversight**: Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

**Public health reporting**: Your health information may be disclosed to public health agencies as required by law.

**Law enforcement**: Your 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.

**Appointment reminders**: The practice may use information to remind you about upcoming appointments. Typically, reminders are sent by mail, in a closed envelope, or, a brief, non-specific message may be left on your answering machine. If you don’t approve of these methods, or, if you prefer alternative methods, please inform the practice.

**Other uses and disclosures**: Disclosure of your health information or its use for any purpose other than those listed above requires 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 affect or undo any use or disclosure of information that occurred before you notified us of your decision.

## 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 North Tarrant Family Practice, please contact:

**The Privacy Officer**
**North Tarrant Family Practice**
**5445 Basswood, Suite 650**
**Fort Worth, Texas 76137**
**817/485-0161**

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is:

**Office for Civil Rights**
**US Department of Health and Human Services**
**200 Independence Avenue, S.W.**
**Room 509F, HHH Building**
**Washington, DC 20201**

3-18-03

# NORTH TARRANT FAMILY PRACTICE

# PRIVACY POLICY

5445 Basswood Blvd
Suite 650
Fort Worth, Texas 76137
817/485-0161

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

## I, _____, have received a copy of North Tarrant Family Practice Associates' Notice of Privacy Practice.

_____ _____

**Signature of Patient** **Date**

## RELEASE OF INFORMATION:

I authorize North Tarrant Family Practice Associates office to release medical, appointment, and/or financial information over the telephone and/or to release copies of my medical records to the following person (s).

_____ Relationship_____

__ __ __ __ (The last 4 digits of your SSN)

## OR

_____ **AT THIS TIME I DO NOT** want any information released to anyone other than myself.

Patient Name _____ Date _____

Signature _____

***ASSIGNMENT OF INSURANCE BENEFITS***
***I AUTHORIZE THE RELEASE OF INFORMATION TO PROCESS ANY AND ALL CLAIM(S). I certify this information is true and correct to the best of my knowledge. I aknowledge I am responsible for payment/co-payment at time of service. Claims unpaid by insurance after 60 days become the responsibility of the patient.***

_____ ***Date:*** _____

***Patient Signature***

_____

***Patient Name Printed***

# NORTH TARRANT FAMILY PRACTICE ASSOCIATES

David C. Haefeli, MD  Sudha R. Jogimahanti, MD  Robert A. Hodgson, MD  Dana S. Kirby, MD

## PATIENT INFORMATION

Patient Name:_____Sex: M F
**Last** **First** **MI**

Address _____Apt #_____ City_____ ST_____ Zip_____

Mailing Add_____City_____ST_____Zip_____

Birth Date_____Age_____SS#_____-_____-_____Marital Status S M D W

( )____-_____ ( )____-_____ ( )____-_____
Home Phone Work Phone Cell Phone

Employment Status: Full-time / Part-time / Not Employed / Self / Retired / Active Duty Employers Name _____
(circle all that apply)

Student Status: Full-time / Part-time / Not a student (circle one) **Driver license number**__ _____

Home e-mail address_____**May we contact you via e-mail on behalf of NTFP or North Tarrant Skin Care? Yes No**

Emergency Contact Name_____Relationship to Patient_____Phone_____

## RESPONSIBLE PARTY'S NAME AND ADDRESS (IF DIFFERENT FROM ABOVE)

Name_____Address_____Relationship_____

City_____ State_____ Zip_____ SSN_____DOB_____

## PRIMARY INSURANCE INFORMATION

**Primary Insurance**_____Policy Holder Name_____

Policyholder's Sex_____Policyholder's DOB_____Policyholder's SSN_____

Patient's Relationship to Policyholder_____Policy Effective Date_____

Policyholder's Employer_____Member ID#_____

Group #_____ Policy Type: Is this insurance coverage obtained thru an employer? Yes or No (circle one)

## SECONDARY INSURANCE INFORMATION

**Secondary Insurance**_____Policyholder_____

Policyholder's Sex_____ Policyholder's DOB _____Policyholder's SSN_____

Patient's Relationship to Policyholder_____Policy Effective Date_____

Policyholder's Employer _____Member ID#_____

Group#_____ Policy Type: Is this insurance coverage obtained thru an employer? Yes or No (circle one)

## AUTHORIZATION FOR PAYMENT AND RELEASE OF INFORMATION

I HEREBY AUTHOIZE PAYMENT TO NORTH TARRANT FAMILY PRACTICE OF ANY MEDICAL BENEFITS. I AUTHORIZE NORTH TARRANT FAMILY PRACTICE TO RELEASE MEDICAL RECORDS, INCLUDING HIV TESTING AND/OR DRUG/ALCOHOL USE AND TESTING, AS REQUESTED BY REPRESENTATIVES OF INSURANCE COMPANIES OR OTHER RELATED ORGANIZATIONS FOR PAYMENT OF CLAIMS, COMMUNICATION DEVICES MAY BE INTERCEPTED OR INADVERTENTLY TRANSMITTED TO PEOPLE NOT AUTHORIZED TO RECEIVE THE NFORMATION, I HEREBY AUTHORIZE THE TRANSMISSION OF MY MEDICAL RECORD, OR ANY PART THEREOF, ELECTRONICALLY AND THRU FACSMILE (FAX) COMMUNICATION DEVICES. ADDITIONALLY, I UNDERSTAND THAT SOME PROCEDURES/SERVICES PERFORMED BY THE PHYSICIAN(S) MAY NOT BE COVERED BY MY INSURANCE PLAN. IF SERVICES ARE NOT COVERED, I UNDERSTAND AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYMENT FOR SUCH SERVICES.

**OFFICE VISIT POLICY**: UNLESS OTHER ARRANGEMENTS ARE MADE, ALL OFFICE SERVICES MUST BE PAID AT THE TIME OF SERVICE. WE REQUEST 24 HOURS NOTICE FOR CANCELLATION OF AN APPOINTMENT. WE RESERVE THE RIGHT TO CHARGE **$25.00** FOR FAILURE TO NOTIFY US OF A CANCELLATION. THIS IS A DIRECT CHARGE TO THE RESPONSIBLE PARTY AND IS NOT BILLED TO INSURANCE.

**I WILL NOT HOLD NORTH TARRANT FAMILY PRACTICE LIABLE FOR MISSING OR ERRONEOUS INFORMATION CONTAINED ON THIS FORM.**

**HMO AND PPO POLICY:** IF YOU ARE ON AN HMO OR PPO PLAN THAT WE ARE PARTICIPATING IN, WE WILL ACCEPT ASSIGNMENT. HOWEVER, PATIENTS ARE REQUIRED TO PAY ANY DEDUCTIBLE OR CO-PAYMENT THAT MAY BE APPLICABLE. ****IT IS YOUR RESPONSIBILITY TO VERIFY THAT WE ARE CURRENTLY PARTICIPATING ON YOUR INSURANCE PLAN(S) OR THAT A SPECIFIC SERVICE IS COVERED.**

PATIENT OR GUARDIAN SIGNATURE:_____DATE:_____

# History and Physical

NORTH TARRANT Family PRACTICE
5445 Basswood Blvd, Suite 150, Fort Worth, Texas 76137
Phone 817.485.0161 Fax 817.485.9430

| Name | Date of Birth | SSN# | Today's Date |
|---|---|---|---|
| | | | |
| **Address** | **Occupation** | **Work Phone** | **Home Phone** |
| | | | |
| | **Chief Complaint** | | **Insurance #** |
| | | | |

| Hospitalization / Surgeries | | | | Drug Allergies |
|---|---|---|---|---|
| Date | Reason | Date | Reason | |
| | | | | |
| | | | | |
| | | | | |

| Medications | Dosage | Vaccine | Year of Last | Test / Exam | Year of Last |
|---|---|---|---|---|---|
| | | Tetanus | | Rectal / Stool | |
| | | Flu | | Cholesterol | |
| | | Pneumonia | | Tuberculosis | |
| | | Other_____ | | Other_____ | |

## Medical History

- ☐ Ringing in ear
- ☐ Ear Infections - Frequent
- ☐ Dizziness / Fainting
- ☐ Failing Vision
- ☐ Eye Infections
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Sore Throats - Frequent
- ☐ Hayfever / Allergies
- ☐ Pneumonia
- ☐ Bronchitis / Chronic Cough
- ☐ Asthma / Wheezing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Swollen Ankles
- ☐ Leg Pain - Walking
- ☐ Varicose Veins / Phlebitis
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Indigestion / Heartburn
- ☐ Persistent Nausea / Vomiting
- ☐ Peptic Ulcers
- ☐ Abdominal Pain - Chronic
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Change in Bowel Hab
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoid
- ☐ Hernia
- ☐ Urine Infections - Frequent
- ☐ Blood In Urine

Urination - ☐ Painful ☐ Loss of Control
☐ Overnight More Than Twice
☐ Decrease in Force / Flow

- ☐ Kidney Stones
- ☐ Veneral Disease
- ☐ Urethral Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss - Recent
- ☐ Anemia ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremor / Hands Shaking
- ☐ Muscle Weakness
- ☐ Numbness / Tingling Sensations
- ☐ Headaches - Frequent
- ☐ Arthritis / Rheumatism
- ☐ Osteoporosis
- ☐ Back Pain - Recurrent
- ☐ Bone Fracture / Joint Injury
- ☐ Gout
- ☐ Foot Pain ☐ Cold Numb Feet
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Nervousness ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness - Excessive
- ☐ Phobias
- ☐ Mental Illness
- ☐ Lactose Intolerance
- ☐ Prostate Disease
- ☐ Sexual / Menstrual Dysfunction
- ☐ Frequent Infections
- ☐ Diphtheria
- ☐ Tetanus
- ☐ Chicken Pox ☐Polio ☐Mumps
- ☐ Measles ☐ Rubella ☐ Rheumatic Fever
- ☐ Scarlet Fever ☐ Tuberculosis ☐ Herpes
- ☐ Other _____
- ☐ Other _____

**Females** - *Please Complete*
Pregnant? ☐ Yes ☐ No
Planning Pregnancy? ☐ Yes ☐ No
Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain / Cramps
_____ Days of Flow _____Length of Cycle
Date - First day of last period _____
☐ Pain / Bleeding during or after sex
**Number of**
_____ Pregnancies _____ Abortions
_____ Miscarriages _____ Live Births

Birth Control Method _____
B/C Pills (name) _____
☐ Flushing / Menopause
Date of Last PAP Test _____
☐ Normal ☐ Abnormal

Date of Last Mammogram _____
☐ Normal ☐ Abnormal

## Family History

| | Father | Mother | Children | Siblings | Father's Parents | Mother's Parents |
|---|---|---|---|---|---|---|
| Alcoholism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Migraine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Habits

☐ Alcohol: Type _____ Amt_____

☐ Diet Salt Intake _____ Fat Intake _____

☐ Sleep Difficulty Falling Asleep _____
Continuity Disturbances _____
Early Morning Awakening _____
Daytime Drowsiness _____

☐ Smoke Packs Daily _____ How Long _____
Interested in Stopping? ☐ Yes ☐ No

☐ Exercise Routine: _____
_____

☐ Coffee Cups Daily _____
Other Caffeine _____