

DEAR PATIENT:

THIS NOTICE 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 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 RESPONSIBILITIES

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

NORTH TARRANT FAMILY PRACTICE ASSOCIATES

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 \$50.00 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: _____

NORTH TARRANT FAMILY PRACTICE ASSOCIATES

ACKNOWLEDGEMENT

Revision date: January 02, 2024

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

NTPF is furnishing you and the attached notice, which provides information about how NTPF and its physicians may use and/or disclose protected information about you for treatment, payment, healthcare operations and as otherwise allowed by the law. By signing this form, you acknowledge that you have received a copy of Notice of Health Information Practices.

Patient/Guardian Signature: _____ Date: _____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians of this medical office to render routine medical care of the patient indicated on this form and to fulfill the orders of the physicians, including consultants associates, and assistants of the physician choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient/Guardian Signature _____ Date: _____

FOR MINORS

If the patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

Patient/Guardian Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to NTPF and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to NTPF. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of NTPF, if any.

OFFICE VISIT POLICY: We reserve the right to charge \$50.00 for failure to notify us of a cancellation. This is a direct charge to the responsible party and is not billed to insurance.

It will be your responsibility to verify that we are currently participating on your insurance plan(s) or that a specific service is covered.

PATIENT/GUARDIAN SIGNATURE: _____ DATE

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

NORTH TARRANT FAMILY PRACTICE ASSOCIATES

PATIENT NAME: _____

EMAIL: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

WHO TO CONTACT

I hereby give permission to North Tarrant Family Practice Associates to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s).

Name		Relationship		Number	
Name		Relationship		Number	
Name		Relationship		Number	

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

HOW CAN WE CONTACT YOU?

Communication by phone

Home Telephone: ()		Work Telephone: ()	
	Okay to leave a message with Detailed information		Okay to leave message with detailed information
	Leave message with call-back Number only		Leave message with call-back number only

Written Communication

	Okay to mail to my home address
	Okay to mail to my work address
	Okay to fax to this number:

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand the Requests for medical information from persons not listed above will require a specific authorization Prior to the disclosure of any medical information.

Patient/Guardian Signature _____ Date: _____



David C. Haefeli, MD
Robert A. Hodgson, MD
Dana S. Kirby, MD
Amy L. Mitchell, FNP-BC

Mid-Level Provider Consent for Treatment

North Tarrant Family Practice has on staff Mid-Level Providers to assist in primary medical care.

A Mid-Level Provider is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician. A Mid-Level Provider is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. Mid-Level Providers conduct physical exams, diagnose, and treat illnesses, order, and interpret tests, counsel on preventative health care, and write prescriptions. In addition, the Mid-Level Providers may treat minor lacerations and other minor injuries, as well as perform surgical procedures.

I have read the above, and hereby consent to the services of the Mid-Level Provider for my healthcare needs.

I understand that at any time I can refuse to see the Mid-Level Provider and request to see a physician.

Patient Name

Date

Patient/ Guardian Signature