NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

PATIENT'S FULL NAME			MAIDEN NAME
ADDRESS	APT#		PHONE NUMBER ( ) EMAIL:
CITY	STATE	ZIP	WORK NUMBER ( ) CELL NUMBER ( )
SEX ☐F ☐M	MARITAL STATUS ☐SINGLE ☐DIVORCED ☐MARRIED ☐ WIDOWED ☐OTHER	DATE OF BIRTH MM/DD/YY	PATIENT'S SOCIAL SECURITY #
PATIENT'S EMPLOYER			
EMPLOYER'S ADDRESS			
SPOUSE'S/GUARDIAN'S NAME	WORK # ( ) CELL # ( )	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY #
EMPLOYER		ADDRESS	
IN CASE OF EMERGENCY, CONTACT		RELATIONSHIP	PHONE # ( )

PRIMARY INSURANCE COVERAGE			
INSURANCE COMPANY		INSURED'S DOB	☐SELF ☐ PARENT ☐SPOUSE ☐OTHER
NAME OF INSURED			COPAY AMOUNT
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS			INSURANCE CO. PHONE #
CITY		STATE	ZIP
POLICY NUMBER	GROUP NUMBER		INSURED'S SOCIAL SECURITY #

SECONDARY INSURANCE COVERAGE			
INSURANCE COMPANY		INSURED'S DOB	☐SELF ☐ PARENT ☐SPOUSE ☐OTHER
NAME OF INSURED			COPAY AMOUNT
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS			INSURANCE CO. PHONE #
CITY		STATE	ZIP
POLICY NUMBER	GROUP NUMBER		INSURED'S SOCIAL SECURITY #
ANY OTHER INSURANCE COVERAGE	☐YES ☐NO	COMPANY NAME	PHONE # ( )
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?			PRIMARY CARE PHYSICIAN

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Providence Medical Partners to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Providence Medical Partners. I understand that I am ultimately responsible for all services whether by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE:_____SIGNATURE:_____

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

PATIENT HISTORY FORM

DATE TODAY:_____

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE AND WILL NOT RELEASE WITHOUT SIGNED CONSENT. It may be sent to consultants, if referred.

NAME:_____ Birth date:_____AGE:_____
LAST FIRST M.I.

MARITAL STATUS: ( ) SINGLE; ( ) MARRIED; ( ) WIDOWED; ( ) SEPARATED; ( ) DIVORCED

OCCUPATION:_____

REASON FOR VISIT TODAY:_____

LAST MEDICAL EXAM:_____ **LAST DOCTOR:**_____

LAST CHEST X-RAY (Date and location):_____

ALLERGIES (DRUGS, X-RAY DYE, TAPE, LATEX) **& type of reaction**:_____

*PHARMACY NAME & PHONE #:*_____

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING THOSE NOT PRESCRIBED, SUCH AS ALTERNATIVE AGENTS OR HERBAL AGENTS).

DRUG	STRENGTH	HOW OFTEN YOU TAKE PER DAY	LENGTH OF TIME YOU HAVE TAKEN
i.e.: Advil	200 mg	3 times per day	6 months

Please know what drugs and doses you take; if you need refills let the nurse know when she places you in the exam room.

CHILDHOOD ILLNESSES: Chicken Pox ( ) Measles/Rubeola ( ) Mumps ( ) Rubella ( ) Scarlet fever ( )

PREVIOUS MEDICAL ILLNESS/HOSPITALIZATION (other than under surgery):

***If Diabetic**, do you self-test with glucose meter?_____Do you get yearly eye exams?___Have you been to a self-management course?_____Do you know what to do for low blood sugar?_____Foot care?_____
_____HgbA1C current value?__

SURGERY: (IF YES, PLEASE CHECK ( ) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( )Appendectomy_____( )C-Section_____( )Hernia repair_____
( )Breast Biopsy_____( )Gallbladder_____( )Hysterectomy_____( )Ovary: R_____L_____
( )Carotid artery_____( )Heart angioplasty_____( )Mastectomy_____( )Stomach surgery_____
( )Cataracts_____( )Heart bypass_____( )Prostate removal_____( )Tonsillectomy_____

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

OB/GYN History: Pregnancies: #_____Deliveries: #_____ Last menstrual cycle: _____

****Check the following items below:**

Tobacco use**:** _____ Yes____No

# of packs per day:_____

# of years: _____

Are you interested stopping? Yes____No____

Tobacco use in past_____ Yes____No

When did you stop?_____

If you continue to smoke, exercise regularly! When ready to stop, call if you want help.

Alcohol use_____

Beer_____Wine_____Liquor_____# of ounces/glasses/cans per week on average:_____

***** Do not mix drinking and driving please. *****

Caffeine use_____

Coffee:_____cups per day. Sodas:_____cans/ounces per day:_____

Exercise

Type:_____Times per week:_____

*** Goal of 30 minutes of walking-type exercise 5 days per week recommended. **

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

PATIENT HISTORY FORM

NAME: _____ Date of Birth_____/_____/_____
Last First M.I.

FAMILY HISTORY: Place an "X" in the space next to the condition that your family member has, then specify their relation to you after the condition, using the following abbreviations:

Mother (M); Father (F); Brother (B); Sister (S); Grandparent (GP); Aunt (A); Uncle (U)

For example, if your Aunt and Mother had breast cancer: (X) Breast Cancer A, M

( ) Alcoholism	( ) Colon Polyps	( ) High Blood Pressure	( ) Prostate cancer
( ) Anemia	( ) Colon cancer	( ) Iron Disease	( ) Seizures
( ) Asthma	( ) Diabetes	( ) Kidney Disease	( ) Thyroid disease
( ) Arthritis	( ) Glaucoma	( ) Mental Illness	( ) Tuberculosis
( ) Bleed easily	( ) Gout	( ) Migraine	
( ) Breast Cancer	( ) Heart Disease	( )Osteoporosis	

	LIVING	AGE ORAGEATDEATH.	Present health or cause of death
FATHER	( ) Yes ( ) No	_____	_____
MOTHER	( ) Yes ( ) No	_____	_____
SIBLING	( ) Yes ( ) No	_____	_____
SIBLING	( ) Yes ( ) No	_____	_____

Immunizations: (Please check the disease against which you have been immunized and date of last booster.)
Tetanus or Td booster is due every 10 years. Let the nurse know if you are due for a booster.

( ) Hepatitis B	( ) Tetanus	( ) Measles/Mumps/Rubella
( ) Pneumonia	( )Heapatitis A	( ) D.T. (Diphtheria/Tetanus)
( ) Varicella	( )Flu Vaccine	( ) Meningitis vaccine

***If you have Hepatitis C or chronic liver disease, talk to your doctor about keeping up to date with your shots. You may benefit from Hepatitis A or B vaccine, or even the Pneumonia shot.

***If you have lung disease, keep up to date with the Influenza and Pneumonia shots.

Illicit Drugs Use? Please discuss with your physician.

Risk factors for AIDS & Hepatitis B and C are the following. If any apply, please let your physician know during your visit. We will observe confidentiality.

Blood transfusion; homosexual relations; IV drug use; relations with IV drug user; needle sticks; work with body fluids, such as dental work, nursing, ER, etc.; sex with multiple partners.

Mark with an "X" if YES or write "NO", for the following items.

_____Diet: Are you interested in information on diets for weight or cholesterol or diabetes?

_____Calcium intake: Do you know women need about 1000mg of calcium intake per day?

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

_____Bone Density tests: check if interested in information; considered after age 50 in women.

_____**Colon exams:** Did you know most experts recommend a colon exam every 5 years, after age 50? Please let us know if you have a family history of colon cancer.

_____**Mammography:** recommended yearly in women after age 40; check if due for this test.

Safety Measures: Examples of action you can take are: Seat belts (every time), bicycle helmets (even adults), wrist protection during roller-blading, eye protection (weed-eating, power sawing, etc.), proper gun use (locking, unloading, keeping out of children's access).

Advanced Directives: Please discuss with your spouse or family and your physician.
Living Will: No ( ) Yes( ) Organ Donor: No ( ) Yes ( )

Durable Power of Attorney for Health Care: No ( ) Yes ( ) Who is your POA for Health Care?_____

PLEASE PLACE A "**Y"** BY THE CURRENT COMPLAINT OR ALIMENT THAT APPLIES TO YOU, IF UNSURE, PLACE A QUESTION MARK "?", IF IT DOES NOT APPLY, PLACE AN " **N"**.

HEAD	_____	BLURRED VISION
	_____	LAST EYE EXAM DATE
	_____	GLAUCOMA
	_____	FREQUENT HEADACHES
	_____	MIGRAINE HEADACHES
	_____	LUMPS OR SWELLING IN NECK
	_____	CONSTANT RINGING IN EARS
	_____	HEARING PROBLEMS
	_____	FREQUENT EAR ACHES
	_____	FREQUENT NOSE BLEEDS
	_____	SINUS INFECTION
	_____	ALLERGIES/HAYFEVER
	_____	HOARSE VOICE, PERSISTENT
	_____	MOUTH OR TONGUE SORES
LUNGS	_____	ASTHMA
	_____	HAVE COUGHED UP BLOOD
	_____	INCREASING SHORTNESS OF BREATH
	_____	EMPHYSEMA
	_____	HISTORY OF TUBERCULOSIS
	_____	CHRONIC COUGH
HEART	_____	FREQUENT IRREGULAR HEART BEAT
	_____	CHEST PAIN OR TIGHTNESS IN CHEST
	_____	HEART MURMUR
	_____	HISTORY OF ENLARGED HEART
	_____	SHORTNESS OF BREATH AT NIGHT
	_____	SWELLING OF FEET, ANKLES PRESENT
	_____	HISTORY RHEUMATIC FEVER

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

	_____	HIGH BLOOD PRESSURE
	_____	PREVIOUS HEART ATTACK
	_____	FREQUENT HEART BURN
ABDOMEN	_____	DIFFICULTY OR PAIN IN SWALLOWING
	_____	HAVE VOMITED BLOOD
	_____	RECTAL PAIN OR BLEEDING (BLACK OR BLOODY)
	_____	RECENT CHANGE IN BOWEL HABITS
	_____	DIVERTICULITIS or DIVERTICULOSIS
	_____	COLON POLYPS
	_____	Last Colon examdate:_____
	_____	HEPATITIS/YELLOW JAUNDICE
	_____	LIVER DISEASE
	_____	NAUSEA
	_____	CONSTIPATION
	_____	DIARRHEA; how often per day_____
	_____	ABDOMINAL PAIN WITH Fatty Food
	_____	HEMORRHOIDS
	_____	HISTORY OF ULCERS
	_____	BLEEDING
	_____	LOSS OF APPETITE
	_____	SEIZURE
	_____	LOSS OF CONSIOUSNESS
	_____	DOUBLE VISION
	_____	MEMORY LOSS
	_____	NUMBNESS OF HANDSOR FEET
	_____	NERVOUSNESS AFFECTING HOME LIFE OR WORK
	_____	SPEECH PROBLEMS
	_____	STROKE
	_____	RECURRENT URINARY TRACT INFECTION
	_____	URINATION AT NIGHT MORE THAN ONCE
	_____	BROWN, BLACK OR BLOODY URINE
	_____	BURNING ON URINATION
	_____	KIDNEY STONES
	_____	DIFFICULTY STARTING STREAM
	_____	PROBLEMS WITH SEXUAL FUNCTION
	_____	URINARY INCONTINENCE
	_____	BACK TROUBLE
	_____	SWOLLEN JOINTS
	_____	FREQUENT PAINFUL FEET
	_____	FREQUENT SHOULDER PAIN
	_____	FREQUENT OR PERSISTENT ACHING OF MUSCLES OR WITH ACTIVITY
	_____	GOUT
	_____	ARTHRITIS
	_____	OSTEOPOROSIS-How diagnosed?_____
GENERAL	_____	DIABETES: Datediagnosed:_____

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

	_____	WEIGHT LOSS GREATER THAN 10 LBS IN LAST YR
	_____	LOSSOF INTERESTIN EATING
	_____	SLEEPING DIFFICULTY
	_____	HERPES IN PAST-genital or face
	_____	THYROID PROBLEMS AFTER SLEEP
	_____	MOLE OR SORE NOT HEALING
	_____	HOT OR COLD NATURED
	_____	SUSPECT SERIOUS DISEASE OR CANCER
	_____	LEG CRAMPS WHILE WALKING
	_____	MORE THIRSTY LATELY
	_____	FATIGUE
	_____	FREQUENT CRYING SPELLS ,DEPRESSION
	_____	WORK OR FAMILY PROBLEMS
	_____	ANXIETY
	_____	ANEMIA
	_____	HIGH CHOLESTEROL & last result _____
MALES ONLY	_____	WEAK URINE STREAM
	_____	PAINFUL OR SORE GENITALS (PRIVATES)
	_____	PROSTATE TROUBLE
	_____	HARD TO EMPTY BLADDER COMPLETELY
	_____	PERFORM SELF TESTICLE EXAM MONTHLY
	_____	LAST PSATEST (if over age 50). DATE _____
FEMALES	_____	LAST MENSTRUAL PERIOD_____
	_____	PAINFUL OR SORE GENITALS (PRIVATES)
	_____	LUMPS OR PAIN IN BREASTS
		IF YOU SEE A GYNECOLOGIST, LIST NAME
	_____	_____
	_____	Last Bone Density Test Date _____
	_____	LAST MAMMOGRAPHY Date_____
	_____	LAST PAPSMEAR Date_____
	_____	PERFORM SELF BREAST EXAM MONTHLY

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Providence Medical Partners

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Providence Medical Partners unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Providence Medical Partners' infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids.

This disclosure is to inform you that you may be tested, at the expense of Providence Medical Partners, if any of these situations occur during your treatment period.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

_____ _____

Witness Date

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Consent to Contact

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

FINANCIAL POLICY

Thank you for choosing the Providence Medical Partners as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

It is your responsibility to provide us with your most current insurance information.

If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and

failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.

We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

It is your responsibility to provide us with your most current billinginformation.

You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30- days after receipt of the initial statement. You can call (817) 514-5200.

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Providence Medical Partners. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.

In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

_____ _____

Signature of Responsible Party Date

Patient Name:_____ Patient's Date of Birth: _____

EPM Medical Record Number: _____

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Authorization to Release Medical Information To Providence Medical Partners

I,_____, hereby authorize_____

(Name of patient or legal representative) (Name of person/entity who should release records)

_____

(Address of person who should release records)

To release the following information by mail, fax, electronically or orally to:

Providence Medical Partners

_____

_____

_____

From the health records of:_____

(Name of person whose record will be disclosed) (Social Security Number)

For the purpose of: _____

All records

☐Statements of charges or payments ☐Progress Note

☐Records of all visits ☐Discharge Summary

☐AIDS or HIV information ☐Consultation Reports

☐History and Physical Examination ☐Hepatitis information

☐Record of visit for a specific date(s) ☐Photographs, videotapes, digital, or other images

Specific dates include or are limited to: _____

☐Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

☐Mental health and/or alcohol and drug abuse treatment

☐Other (must be specific): _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Sierra Providence Medical Partners, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.

PHYSICIAN'S NAME: _____

6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____	_____
Patient's Printed Name	Date of Birth
_____	_____
Patient/Legal Representative Signature	Date
_____	_____
Relationship to Patient	Expiration Date of Authorization
_____	_____
Witness	Date

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Providence Medical Partners reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Relationship to Patient Expiration Date of Authorization

_____ _____

Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Sierra Providence Medical Partners to share my protected health information with:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Notice of Privacy Practices

(Please keep this for your records)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IFYOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER MICHAEL TAMAYO AT (210) 619-8845 OR BY EMAIL AT Michael.Tamayo@tenethealth.com .

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services.

We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, www.ProvidenceMedicalPartners.com, or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

An updated copy will also be posted in your physician's office.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a radiologist or pathologist) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare (Clinic) Operations: We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and nursing students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical and nursing school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services, telephone answering services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may send you information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in

your best interest. In this case, only the protected health informationthat is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instances:

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health

information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: If you choose to participate in medical or scientific research, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel

(1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally- established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses to make decisions about your health care. The request must be made in writing to Providence Medical Partners. If you request a copy of your medical record, your physician's office will provide you a copy within 30 days.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting your written request to the manager of your physician's clinic.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by

asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer at 8200 Perrin Beitel, San Antonio, Texas 78218.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information for the purpose of correcting an error or misinformation. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and that statement will become part of your medical record. Your physician may prepare a rebuttal to your statement which will also become part of your medical record. Your physician will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Questions or Complaints

If you have a question or complaint about your privacy rights, please file a grievance form with the site manager of the clinic where you encountered a problem, or contact the Regional Privacy Officer for Providence Medical Partners at (210) 619-8845. Should the HIPAA Privacy Officer be unable to resolve your complaint to your satisfaction, you may contact the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

This notice became effective on April 14, 2003. Revisions/Addenda to Notice of Privacy Practices

Family/Joint Accounts

If you or a family member receives bills with more than one person listed on the bill, you may have a joint or family account through Providence Medical Partners. As a patient with this type of account, you have two options:

(1) continue with a joint account or (2) request separate accounts for all members of your family. If you wish to continue to receive your bills as a joint/family account, you need take no action. If you choose to separate your joint accounts, requests must be made in writing and submitted to:

Providence Medical Partners Central Business Office Customer Service/ Collections Personnel 9003 Airport Freeway, Suite 300 North Richland Hills, Texas 76180 (817) 514-5200 phone (817) 514-5210 fax

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

PLEASE CALL YOUR INSURANCE COMPANY

We will do our best to verify your coverage. Knowing your benefit coverage, however, is your responsibility and will help you to understand services for which you may be financially responsible.

With so many changes that insurance companies are making, won't you please take time to learn how they will affect you and your family?

PROVIDENCE MEDICAL PARTNERS
www.ProvidenceMedicalPartners.com
844-ELP-DOCS (844-357-3627)

As you are probably aware, coverage under most health insurance policies HAS CHANGED. In an effort to assist our patients in understanding their insurance coverages, we have defined the following as questions that you should ask your insurance company. Whether you have a new insurance company (or you have had the same insurance plan for years), these questions should be asked TODAY to determine any changes in coverage. These are only a few suggestions, so please ask any other questions you may have when you make the call.

1. What is my effective date?
2. If I am covered by more than one insurance, which insurance is primary? Which is secondary? Which company is the primary for my child if both my spouse and I have coverage?
3. Is my insurance an HMO, POS, PPO or indemnity? What does this mean?
4. Do I have out of network benefits?
5. Does my insurance require written referrals to specialists?
6. Do I have a deductible? What does that mean to me, and how much has been met? What is the deductible for?
7. Will I have co-insurance amounts due over and above my copay? If yes, what are those amounts?
8. What is my doctor (PCP) office visit copay? Specialist office visit copay? Is my OBGYN treated as a specialist if I only go for my annual gynecological visit?
9. How often can I and/or family members have a preventive physical/well woman exam/well child visit? According to your records, when did I and/or my family members last have these types of exams? Is there a copay for a preventive physical/well woman exam/well child visit? How much? When I and/or family members have a preventive physical/well woman exam/well child visit, is there anything that is NOT covered? How much do I have to pay?
10. Is there a cost limit, coinsurance or deductible on my preventive coverage? If so, how much?

PHYSICIAN'S NAME: _____

11. Is there a copay, coinsurance or deductible if I have labs or procedures done without seeing the physician or physician assistant? What if the procedures or lab work occur on a day(s) before or after my appointment?
12. Do I have coverage for screening tests? (Colonoscopy, stress test, labs, mammograms, bone density testing, EKG, etc.) If so, what is the rate at which these tests are covered?
13. Do I have coverage for preventive immunizations? Travel Immunizations? Is there a co-pay when I go to the doctor for immunizations only? For children, is there an annual cost limit for preventive immunizations? If yes, how much?
14. What pre-existing conditions are NOT covered by my insurance?

NOTE: Medicare patients should find out when co- payments apply, especially when Medicare is offering a particular health service/exam.

Other Notes:

NEW PATIENT INFORMATION PACKET –PROVIDENCE MEDICAL PARTNERS

PHYSICIAN'S NAME: _____

Providence Medical Partners HIPAA Patient Education

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law passed by Congress to protect patient privacy with regards to medical records and to control the flow of health information. Also, HIPAA was designed to lower administrative costs by setting standards for the filing and processing of insurance claims. HIPAA regulations will affect people at all levels of healthcare, including patients and their physicians.

What is TPO?

Treatment, payment, and operations (TPO) include the routine processes involved in receiving healthcare. There are several examples that encompass TPO. Oftentimes it is necessary to share your health information between healthcare providers, such as providing a referral to a specialist. This is a part of **treatment**. Information about your diagnosis and other health information is required for **payment** from insurance companies. Evaluations of medical records to ensure high quality care provided by our physicians are considered part of **operations.**

Why should I care about TPO?

HIPAA legislation outlines significant differences for the handling of health information for TPO and reasons other than TPO. The laws created by HIPAA are designed to expedite healthcare by placing no restrictions on the sharing of your health information for TPO and severely restricting information not required for TPO (e.g. releasing information to other people, even your family members, or for marketing reasons).

How will HIPAA affect me as a patient?

HIPAA will benefit patients in many ways. For example, Sierra Providence Medical Partners will provide all patients with information about their rights to privacy. Also, the new regulations make it illegal for healthcare providers to sell your health information to marketers and advertisers without your written authorization. As a patient, you have the right to review your medical record if you believe something is incorrect and request a change. However, only your physician can determine if your medical record is inaccurate.

Does HIPAA have any negative effects?

The intention of HIPAA legislation is to improve the level of privacy for patients. **However, the law requires the patient's written permission before his or her health information can be released for reasons other than TPO. For example, relatives cannot call the clinic and get any health information without you signing an authorization first. Please understand the clinic is working to protect the privacy of all patients and may have stricter policies for the release of such information.**

PHYSICIAN'S NAME: _____

When did these changes take place?

HIPAA regulations went into effect April 14, 2003.

Who should I contact if I have concerns about the privacy of my Providence Medical Partners medical record?

Providence Medical Partners has a Regional Privacy Officer available to resolve any privacy issues. Please contact:

HIPAA Privacy Officer
Providence Medical Partners
8200 Perrin Beitel
San Antonio, Texas 78218
(210) 619-8845

Thank you for helping the Providence Medical Partners in our efforts to protect the privacy of ALL our patients!