*The Medical Home Team*
*1901 Medi Park, Ste 1068*
*Amarillo TX 79106*
806-576-1095 or 806-576-1032

**ADULT PATIENT INFORMATION: Please write clearly.**

Patient Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____ City:_____

State_____ Zip_____ Sex: M or F Date of Birth:_____ Age:_____

SSN:_____-_____- _____

Home Phone #:_____ Parent/Guardian Phone #:_____

Which is the best phone number to reach you and/or leave a message? Home Guardian

Home Address (if different from mailing address)_____ City:_____

State_____ Zip_____

**How did you hear about us?** Facebook___ Instagram___ Billboards___ TV___ Radio___ Other_____

*Please check the appropriate box:*

Patient Race: White Black or African American Hispanic Asian American Indian or Alaska Native Declined

Patient Ethnicity: Hispanic or Latin Not Hispanic or Latin Declines

Patient Primary Language: English Spanish Other:_____

Guardian/Responsible Party Last Name:_____ First Name:_____

Address (if different from above):_____

City:_____ State:_____ Zip:_____

Occupation:_____ Employer Name: _____

Employer Address:_____ City:_____ State:_____ Zip:_____

**Please provide insurance card and drivers license to receptionist for responsible party. COPAY AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.**

Policy Holder's Name :_____ Relationship to Patient _____

Policy Holder's SS#_____-_____-_____ Policy Holder's Date of Birth _____

Policy Holder's Employee Address: _____

Policy Holder's Home Phone Number_____ Policy Holder's Work Phone Number_____

**Please provide contact information for nearest living relative, not in your household, that we may contact in case of emergency.**

Name:_____ Relationship:_____

Phone:_____ Alternate Phone Number:_____

Address:_____ City:_____ State_____ Zip _____

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Patient Name:_____ Date of Birth: _____

**Authorization for Review of Medical Records**

The Health Insurance Portability and Accountability Act (HIPPA) require the patient (or parent, guardian or legal representative) to consent for others to look at the patient Medical Records. Please write the names below of relatives or friends, 18 years old or older, that can have access to the patient medical records. These will be the only people to look at or receive information about your health care. Put none if you do not want to list anybody. **We will not disclose information to anyone other than the parent, guardian, or legal representative for minors, that are not listed below.**

| Full Name: | Relationship to Patient |
|---|---|
| | |
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| | |

Patient Signature Date

## RX history

At times, we may need to view the patient's previous prescriptions so that we may care for them to the best of our abilities. By signing this, you grant The Medical Home Team permission to view prescription history from external sources.

Parent/guardian signature Date

*The Medical Home Team*
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## Financial Policy

I authorize the release of any medical information necessary to obtain payment of medical benefits from my health insurance company. I authorize my insurance company to pay The Medical Home Teamany medical benefits due for their services. I understand that I am responsible to pay deductibles, copays and any other charges not paid by my insurance company.

Our policy is that payment is expected in full at time of service, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company, initially, for services rendered. You are responsible for repeated filings of insurance or filing to secondary insurance. Co-payments and deductibles are due at time of your office visit. There is a $30.00 return check fee. If your account becomes delinquent, you are responsible for your bill plus all collection costs. Please read our additional office policy form for further information regarding payment policies.

I authorize The Medical Home Team to contact me via current and any future cellular phone number(s), email address(es) or wireless device(s) regarding my delinquent account(s) or debt I owe to The Medical Home Team or to receive general information from The Medical Home Team. I also authorize The Medical Home Team and its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails in their effort to contact me for purposes of collecting any portion of my account financial obligation which is past due. Furthermore, I understand I may withdraw my consent to call my cellular phone by submitting my request in writing to The Medical Home Team or its agents on behalf of The Medical Home Team.

You are responsible for notifying us of any changes in your insurance information, billing address, phone numbers.

You may request a copy of our Notice of Privacy Practices in accordance with HIPPA law. If you would like significant others to receive personal medical information about you, it is necessary to complete a Disclosure Form.

To the best of my knowledge the above information is correct. I understand and agree to comply with the Medical Home Team financial policies.

Patient SIGNATURE:

PRINT PATIENT NAME: Date

*The Medical Home Team*
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*Amarillo TX 79106*
806-576-1095 or 806-576-1032

Medical History Form

Name_____ Date of Birth_____ Today's Date_____

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

**1. Personal Medical History**

Please indicate if you have had any of the following problems currently or in the past.

| | | | |
|---|---|---|---|
| Anemia | ☐ Yes ☐No | | |
| Kidney disease/stones | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Emotional problems | ☐ Yes ☐ No |
| Liver disease/Hepatitis | ☐ Yes ☐ No | Venereal disease/Syphilis | ☐ Yes ☐ No |
| Asthma/Emphysema | ☐ Yes ☐ No | Epilepsy or Seizures | ☐ Yes ☐ No |
| Lung disease/pneumonia | ☐ Yes ☐ No | Gonorrhea/Chlamydia | ☐ Yes ☐ No |
| Bladder infections | ☐ Yes ☐ No | Gallstones | ☐ Yes ☐ No |
| Pancreatitis | ☐ Yes ☐ No | Thyroid disease/Goiter | ☐ Yes ☐ No |
| Chronic diarrhea | ☐ Yes ☐ No | Gout | ☐ Yes ☐ No |
| Rheumatic Fever | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Diverticulosis | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No |
| Skin disease | ☐ Yes ☐ No | Tumors/Cancer | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No |
| Sleep apnea | ☐ Yes ☐ No | Ulcers (stomach or intestinal) | ☐ Yes ☐ No |
| If yes, what age?_____ | | High Blood Pressure | ☐ Yes ☐ No |
| | | Acid Reflux (Heartburn) | ☐ Yes ☐ No |

If yes to any of the above, please explain

_____

_____

_____

When was your last Tetanus shot given? _____

**2. Family History** ☐Adopted, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions? *Family Relationship:* *Living/Deceased:*

| | | | |
|---|---|---|---|
| Alcoholism | ☐ Yes ☐ No | _____ | _____ |
| Anemia | ☐ Yes ☐ No | _____ | _____ |
| Arthritis | ☐ Yes ☐ No | _____ | _____ |
| Bowel/Colon Cancer | ☐ Yes ☐ No | _____ | _____ |
| Breast Cancer | ☐ Yes ☐ No | _____ | _____ |
| Depression | ☐ Yes ☐ No | _____ | _____ |
| Diabetes | ☐ Yes ☐ No | _____ | _____ |
| Heart Disease/Angina | ☐ Yes ☐ No | _____ | _____ |
| Hepatitis | ☐ Yes ☐ No | _____ | _____ |
| High Blood Pressure | ☐ Yes ☐ No | _____ | _____ |
| High Cholesterol | ☐ Yes ☐ No | _____ | _____ |

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*1901 Medi Park, Ste 1068*
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806-576-1095 or 806-576-1032

**3. Personal Habits**

*Tobacco Use*
Cigarettes: ☐ Never ☐ Quit-Date_____ ☐ Current Smoker-Packs per day___ # of years___
Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Hookah
Are you interested in quitting? ☐ Yes ☐ No

*Nicotine Use*
Vape: ☐ Never ☐ Quit-Date_____ ☐ Current User, Tanks per day___ Mg of Nicotine___
Other nicotine: ☐ e-cigs ☐ Hookah Are you interested in quitting? ☐ Yes ☐ No

*Alcohol Use*
Do you drink alcohol? ☐ No ☐ Yes, average # of drinks per week_____
If no, have you in the past? ☐ Yes ☐ No

*Drug Use*
Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills?
☐ Yes ☐ No
Have you ever used needles? ☐ Yes ☐ No.

*Sexuality*
Are you sexually active? ☐ Yes ☐ No ☐ Not currently
If sexually active, do you practice safe sex? ☐ Yes ☐ No
Birth control method_____
Have you ever had any sexually transmitted diseases (STD's)? ☐ Yes ☐ No
If yes, please include_____

*Exercise*
Do you exercise regularly? ☐ Yes ☐ No
If yes, what type of exercises?_____

*Emotions*
In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed;
or when you lost interest or pleasure in things that you usually enjoyed? ☐ Yes ☐ No

**4. Operations**
Have you had any operations? If yes, list:

| Type of operation | Reason for operation Hospital | Facility Date of operation |
|---|---|---|
| | | |
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*Amarillo TX 79106*
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**5. For Women Only**

Total # of pregnancies_____ # of deliveries_____ # of miscarriages_____ # of abortions_____
Age at start of menstrual period _____
Date most recent menstruation began _____
Usual length of menstrual period _____ days
Date of last Pap smear _____
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No
If yes, give date and describe_____
Have you stopped having menstrual periods? ☐ Yes ☐ No If yes, when_____
Do you have regular problems with:
Irregular, painful, or heavy menstrual periods ☐ Yes ☐ No
Bleeding between periods or after menopause ☐ Yes ☐ No
Vaginal discharge, pain or itching ☐ Yes ☐ No
Hot flashes ☐ Yes ☐ No
Pain or lumps in breasts ☐ Yes ☐ No

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*Amarillo TX 79106*
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**Medication List:**

Patient Name: _____ DOB: _____

Drug Allergies: _____

| Date | Medication and Dose | How Often? | How Long? |
|---|---|---|---|
| | | | |
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1901 Medi Park, Ste 1068
Amarillo TX 79106
806-576-1095 or 806-576-1032

# HEALTH INSURANCE CLAIM FORM

Please Sign on lines below. The office Staff will fill out the rest of the form. - Thank you

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

| 1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) |
|---|---|---|---|---|---|---|
| | | | | | | |

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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*Amarillo TX 79106*
806-576-1095 or 806-576-1032

# GENERAL CONSENT FOR TREATMENT

Patient Authorization for the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operation

## CONSENT TO THE MEDICAL HOME TEAM (TMHT) FOR SERVICES

I request and authorize medical care as my physician, his assistant or designees (collectively called "the team") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my "team" to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my "team" and that other personnel render care and services to me (the patient) according to the physician(s) instructions.

- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize The Medical Home Team to dispose of the bodily fluids.
- I have been informed and understand that an HIV (human immunodeficiency virus – AIDS) test may be performed on me without my consent if a health professional or Medical Home Team employee or First Responder sustains an exposure to my blood or other body fluid.
- HIV testing/screening may be performed with verbal explanation and consent. TMHT does not offer anonymous testing. If you request an anonymous HIV test, then TMHT can assist you in locating a facility which does such. You have the right to withdraw your consent for the test at any time before the test is complete. You have the right to ask questions and have them answered prior to the test and after results are reported. Screening for Hepatitis or other infectious diseases may also be performed with a verbal consent. TMHT will report all positive test results to the Department of Health or other agency, as determined by state and local regulations.
- A drug screen by blood or urine sample may be obtained with verbal consent for purposes of verifying compliance with medication regimens or when abuse or misuse is suspected or when signs or symptoms of toxicity exist.
-

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The Medical Home Team Notice of Privacy Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ATC) and acquired immunodeficiency (AIDS); including substance abuse treatment records protected under the regulation 42 Part 2, in the Code of Federal Regulations (if any); and psychological and social services records, including communication made to me to a social worker or psychologist (if any) may be disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting The Medical Home Team office.

- I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or healthcare operations. My physician(s) and The Medical Home Team are not required to agree to this restriction, but if they agree, will be bound by the agreement.
- By signing this form, I acknowledge that I have been offered and/or The Medical Home Team Notice of Privacy Practices.

## AUTHORIZATION TO RELEASE HEALTH INFORMATION

I understand that as part of my healthcare, The Medical Home Team, originates, maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care

*The Medical Home Team*
*1901 Medi Park, Ste 1068*
*Amarillo TX 79106*
806-576-1095 or 806-576-1032

- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

- I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
- I understand and acknowledged that I received a Notice of Privacy Practices, and I consent to such disclosures as delineated in the Notice.
- I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS), Human immunodeficiency virus (HIV), behavioral health service/psychiatric care, treatment for alcohol and/or drug abuse

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under TITLE XVII of the Social Security Act is correct and request on my behalf all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to Thomas Sames MD PA for benefits (payments) otherwise payable to me. I agree to personally pay for any charges that are not covered by or collected from any insurance program, including any deductibles and coinsurance amounts.

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date:_____

*The Medical Home Team*
*1901 Medi Park, Ste 1068*
*Amarillo TX 79106*
806-576-1095 or 806-576-1032

**Medical Records Release Form** **Fax: 806-731-0883**

**Patient information:**

Name: DOB: SSN:

is requesting that The Medical Home Team obtain health information (to/from) the person/company/agency/facility listed below.

Facility Name: _____

Address: _____

Phone:_____

The information to be disclosed relates to service dates beginning _____ and ending _____.

- ☐ Entire Medical Record
- ☐ Medication List
- ☐ Physical Therapy Notes
- ☐ Demographic Information
- ☐ Immunizations
- ☐ Occupational Health Record
- ☐ History & Physical
- ☐ Test Results
- ☐ Medical/ Surgical History
- ☐ Other Assessments
- ☐ Physician Office Notes
- ☐ Discharge Summary
- ☐ Other: _____

**The purpose of the disclosure:** ("Request of the individual" is sufficient for patient-initiated releases)

- ☐ Request of Individual
- ☐ Change of Provider
- ☐ Legal Investigation
- ☐ Referral to Specialist
- ☐ Insurance
- ☐ Continuing Care
- ☐ Workers Comp
- ☐ Other:

Conditions and Notifications:

I understand that I may revoke this consent (in writing) at any time except to the extent that action has been take in reliance on it. This consent will expire 180 days after my signature unless otherwise specified.

Patient Signature Date

*The Medical Home Team*
*1901 Medi Park, Ste 1068*
*Amarillo TX 79106*
806-576-1095 or 806-576-1032

## PRIVACY PRACTICES POLICY: EFFECTIVE DATE: 04/01/2018

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will--

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to. Request a phone number in which the patient will permit us to leave a message.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
    - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--
    - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or
- professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

*The Medical Home Team*
*1901 Medi Park, Ste 1068*
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806-576-1095 or 806-576-1032

# PRIVACY PROCEDURES:

- The Privacy Officer will provide the front office staff with an original form for patients to complete when the patient desires to inspect and copy his/her PHI.
- The front office staff will photocopy and make available to patients the form to Inspect and Copy PHI.
- The front office staff will respond to patients' requests and questions concerning inspecting and copying their PHI. In addition, the front office staff will distribute the form to the patients upon their request.
- Once the patient completes the form, the front office staff should forward the form to the Privacy Officer/Physician for review.
- Once the patient has submitted his/her request in writing (using the practice's form is optional), the front office staff must verify that the patient's signature matches his/her signature on file.
- The Privacy Officer must review the patient's request and respond to the patient within 30 days from the date of the request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the patient in writing with the reason for the delay clearly explained.
- The Privacy Officer should agree to all reasonable requests. If access is denied, the Privacy Officer must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.
- When the patient has requested to inspect their PHI and his/her request has been accepted, the Privacy Officer or other authorized practice representative should accompany the patient to a private area to inspect his/her records and remain with the patient during inspection. After the patient inspects the record, the Privacy Officer will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or changes to the record.
- When the patient's request to copy his/her PHI has been accepted, the front office staff should copy his/her record within ten business days at a charge of $1.00 per page.

_____

Patient Signature Date