



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

**PEDIATRIC 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

### Authorization for Medical Treatment of Minors

By signing this form, the patient parent, guardian, or legal representative give the following people permission to obtain and order medical treatment for this patient. They are of age (18 years or older) to make medical treatment decisions while the parent, guardian, or legal representative is absent, they may also sign any and all medical paperwork so that the patient can receive proper and prompt medical treatment. This is valid until a written notice states otherwise. **We will not allow the patient to be seen without a parent, guardian, or legal representative unless they are listed below or have written permission.**

Full Name:	Relationship to Patient

\_\_\_\_\_  
Patient Signature or Guardian

\_\_\_\_\_  
Date



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## 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.

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Parent/guardian signature

Date

## 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 Team any 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.

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GUARDIAN SIGNATURE:

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PRINT PATIENT NAME:

Date



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<b>Pediatric Medical History: Please Circle if the patient has now( or have had) any of the following:</b>				
Seizures	Bowel Trouble	Bleeding Disorders	Thyroid Disease	Asthma
Migraines	Hemorrhoids	Anemia	Rashes	Tuberculosis
Chickenpox	Hepatitis	Arthritis	Circulatory Problems	Lead Exposure
Allergies	Heart Trouble	Liver Disease	HIV/AIDS	Diabetes
Ear Infections	Heart Murmur	Stomach Ulcers	Cancer _____	Alcohol Abuse
Hearing Trouble	Palpitations	Kidney Infections	Depression	High Cholesterol
Vision Trouble	Kidney Stones	Suicide Attempt		
Blood Clots	Drug Abuse	Other:		
<b>PEDIATRIC REVIEW OF SYSTEMS: Please circle if patient is currently having any of the following symptoms:</b>				
Weight loss/gain	swallowing difficulties	chest pain	excessive urination	
Unusual weakness	Ear Pain	Abdominal Pain	Painful Urination	
Bleeding	Allergies	nausea	blood in urine	
Fever	Neck pain	Vomiting	Joint pain	
Vision changes	Cough	Diarrhea	Back pain	
Hearing changes	Shortness of breath	Constipation	Memory loss	
Nose bleeds	Wheezing	Rectal bleeding	Dizziness	
Leg swelling	Palpitations	Heart burn	Headaches	
Muscle cramps	Rashes	Other:		
<b>Allergies:</b> allergic to anything?		<b>Social History:</b> Who does the child live with?		
		Do any household members smoke?		
<b>Last Physical:</b>		Does the child attend school? If so what grade?		
<b>Are vaccines UTD?</b>		Any problems at school?		
NAMES OF SPECIALISTS PATIENT SEES:				
PREVIOUS SURGERIES:				
<b>FAMILY HISTORY:</b> Circle the following health problems that occur in your family:				
Asthma	Bleeding Disorder	High Blood Pressure	High Cholesterol	
Anemia	Colo n Cancer	Seizures	Obesity	
Diabetes	Depression	Heart Trouble	Other:	
Relation	Age	Health Problems	Deceased?	Cause of death?
Father				
Mother				
Sister				
Brother				
<b>Developmental History:</b>		Any problems at birth?		Premature? Y/N
At what age did your child?		Sit alone? _____	Walk alone? _____	Bedwetting? Y/N
Does your child have any unusual feeding/dietary problems?				
<b>FEMALES ONLY:</b> Could you be pregnant? Y?N			Birth Control Method? _____	
What age did you start your period? _____			Date of last PAP? _____	
NAME:		DOB:		AGE:



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Medication List:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Date	Medication and Dose	How Often?	How Long?



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**HEALTH INSURANCE CLAIM FORM**

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

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

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME	
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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> DATE _____		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. RESUBMISSION CODE ORIGINAL REF. NO.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.				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. EPIDT Family Plan	
				I. ID. QUAL.	
				J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back.) YES <input type="checkbox"/> NO <input type="checkbox"/>	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.)			32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE		a.	b.	a.	b.

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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## 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.
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### 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



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- 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: \_\_\_\_\_





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## Medical Records Release Form

### 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 \_\_\_\_\_.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Entire Medical Record   | <input type="checkbox"/> Occupational Health Record | <input type="checkbox"/> Other Assessments      |
| <input type="checkbox"/> Medication List         | <input type="checkbox"/> History & Physical         | <input type="checkbox"/> Physician Office Notes |
| <input type="checkbox"/> Physical Therapy Notes  | <input type="checkbox"/> Test Results               | <input type="checkbox"/> Discharge Summary      |
| <input type="checkbox"/> Demographic Information | <input type="checkbox"/> Medical/ Surgical History  | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Immunizations           |   |   |

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

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Request of Individual | <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Workers Comp |
| <input type="checkbox"/> Change of Provider    | <input type="checkbox"/> Insurance              | <input type="checkbox"/> Other:       |
| <input type="checkbox"/> Legal Investigation   | <input type="checkbox"/> Continuing Care        |                                       |

### 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



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## 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.



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## **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.