NTMC Health™

A Department of NTMC

PATIENT INFORMATION

Last Name:	First Name:	MI:	
Date of Birth:	Social Security Number:	Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐	
Physical Mailing Address:	City:	State:	Zip:
Email Address:	Home Phone Number:	Mobile Phone:	May we leave a voicemail?: Yes ☐ No ☐
Language: English ☐ Spanish ☐ Other ☐	Gender: Male ☐ Female ☐	Race: Asian ☐ White ☐ Hispanic ☐ Indian ☐ African American ☐ Other ☐	
Parent/Legal Guardian (if patient is a minor) Name:		Guardian Date of Birth:	
Insurance Provider Name:		Subscriber Date of Birth:	
Subscriber's Name:	Relationship to Patient:		
Insurance Member ID#:	Group ID #:	Insurance Phone Number:	
Occupation:			
Emergency Contact Name:	Next of Kin Name:		
Phone Number:	Phone Number:		
Address:	Address:		
Relationship:	Relationship:		

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AUTHORIZATION FOR EMERGENCY TREATMENT/OUTPATIENT SERVICES

INITIAL ALL STATEMENTS BELOW:

1._____Consent for Medical Treatment: I understand that I have presented myself to the NTMC CLINICS for evaluation and/or treatment for a medical condition. I authorize and direct the NTMC CLINICS to provide quality care to me and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

2. _____Medicare and Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment or authorized benefits be made on my behalf. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible and 20% co-Insurance (Part B) relating to any professional charges which may be incurred.

3. _____Pre-Certification Responsibility: I understand that I am responsible for pre-certification/pre-authorization with my insurance carrier. Penalties may be assessed by my carrier as a result of failure to properly certify.

4. _____Scheduled Appointments: We understand that delays can happen, however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

5. _____Return Check Policy: You will be charged $35 for each unfunded or returned check.

6. _____Overpayment: I understand that in the event of an overpayment on the account any refund due will be refunded to the appropriate party, except as follows: It is hospital policy to apply any credit balance that may exist as a result of this clinic visit to any other accounts for myself or a member of my immediate family for whom I am legally responsible. In the event there are no other accounts, a prompt refund will be made.

7. _____Financial Agreement and Payment Guarantee: I hereby give authorization to apply my insurance benefits directly to the NTMC CLINICS for services rendered. I understand that I am financially responsible for all charges that are not covered by my insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement will be as valid as the original.

8. _____Telephone Contacts: I hereby consent to receiving auto-dialed and/or artificial or pre-recorded message calls to my cellular telephone and any phone number provided during my registration process from NTMC or its affiliates and their agents including, without limitation, any account management companies and independent contractors including any collection agents; or send mail via US Mail service.

9. _____Indigent/Charity Care: NTMC has developed an eligibility system to assess patients who may be financially or medically indigent. To apply, contact Patient Navigator at 940-612-8754. Care will be provided to those qualified patients without regard to race, creed, color, or national origin. By virtue of its exemption from federal and state taxes and as part of the hospital's mission to serve the health care of the community, Indigent/Charity Care will be provided to patients without financial means.

10. _____Authorization for Release of Medical Information: I acknowledge that the NTMC CLINICS will share all necessary information with my insurer(s), payer(s), governmental entities such as Medicare, Medicaid, etc., and their representatives including, but not limited to, benefit determination and utilization review, as well as your representatives involved in the billing process including, but not limited to, claims representatives, data warehouses and billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office including, but not limited to, any relevant processes, the credentialing processes, peer review, accreditation, and compliance with all federal and state laws.

11._____ I understand that health care services paid under Medicare, Medicaid, and maternal and child health programs are subject to review by the Professional Standards Review Organization. I also acknowledge that you will share my information with any referring providers involved in my healthcare treatment.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THE FOREGOING, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.

_____	_____	___/___/___
Patient or Guardian Signature	Relationship to Patient	Patient DOB
_____	_____	___/___/___
Patient Printed Name	Witness	Date

NTMC Health™
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PATIENT RIGHTS AND RESPONSIBILITIES

EXERCISE OF RIGHTS

- You also have the right to participate in making care decisions. You have the right to participate in the development and implementation of your plan of care.
- You have the right to refuse or request care if you are competent. This includes the right to refuse any drug, treatment, or procedure offered by law and hospital policy. This right does not extend to services that are medically unnecessary or inappropriate.
- Except in emergencies when a patient lacks decision-making capacity and the need for treatment is urgent, you have the right to discuss and request information related to specific procedures and/or treatments, the risks and benefits, inclusions, and the possible length of recuperation. You also have the right to be informed about medically reasonable alternatives and those accompanying risks and benefits.
- Except for when clinically necessary or a reasonable limitation, you have the right to receive the visitors whom you designate, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend.
- You have the right to withdraw your consent to visitation by any individual at any time.

PRIVACY AND SAFETY

- You have the right to personal privacy. Case discussion, consultation, examinations, and treatment should be conducted in a manner that reasonably safeguards your privacy.
- You have the right to receive care in a safe setting.
- You have the right to be free from all forms of abuse, neglect, or harassment.

CONFIDENTIALITY OF PATIENT RECORDS

- You have the right to access information contained within your medical record within a reasonable time frame.
- You have the right to expect all communications and records pertaining to your care will be treated as confidential except in cases when reporting is permitted or required by law. You have the right to expect that the clinic will emphasize the confidentiality of this information when it releases to other parties entitled to review information explained or interpreted as necessary, except when restricted by law.

Please initial the four statements below for acknowledgment (HIPAA):

PROTECTED HEALTH INFORMATION

_____(initial) If I paid out-of-pocket in full for a specific item or service, I have the right to ask that my Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and the NTMC CLINICS will honor that request. I request that the below services(s) not be disclosed to a health plan for purposes of payment or health care operations.

_____

ACKNOWLEDGMENT OF PATIENT RIGHTS - NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

_____(initial) I acknowledge that the NTMC CLINICS has provided me with the opportunity to view and read a written copy of their NOTICE OF PRIVACY PRACTICES.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND CONSENT TO DISCLOSURE OF INFORMATION

_____(initial) I acknowledge that the NTMC CLINICS will disclose my Protected Health Information (PHI) to a family member, other relative, close friend, or any other person I identify that directly relates to that person's involvement in my care.

Specify individual: _____ Contact number: _____

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITIES

_____(initial) I have read the NOTICE OF PATIENT RESPONSIBILITIES and have had any questions answered by this office. I understand that by signing this form, I acknowledge that I have read the Patient Responsibilities Notice posted in all the NTMC CLINICS locations. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

PATIENT RIGHTS AND RESPONSIBILITIES (continued)

COMMUNICATIONS

- If you cannot communicate with the clinic staff because you do not speak English or are not proficient in English, or you have communication challenges such as deafness, low vision, or blindness, you shall have access, where possible, to an interpreter and/or technology to assist with communication.
- If you should have a complaint, please give us the opportunity to address your concerns by notifying a Patient Contact Representative or the Director of Quality Management. However, you are not required to do so and may file a complaint with the following state agencies:

Physician Issues:
Texas Medical Board Investigations Department, MC-263
P.O. Box 2018
Austin, TX 78768-2018
1-800-201-9353

Hospital Care Issues:
Health Facility Compliance Group/ MC 1979
Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78786
1-888-973-0022

PROVISION OF INFORMATION

- You have a responsibility to provide accurate and complete information related to your health which includes present complaints, past illnesses, hospitalizations, surgeries, current medications, and any allergies you may have. Unexpected changes in your condition should also be reported.
- You have the responsibility to inform your healthcare provider if you do or do not understand your treatment plan and what is expected of you.
- You are responsible for providing necessary and accurate information for insurance claims processing and to fulfill financial obligations promptly.

COMPLIANCE WITH TREATMENT INSTRUCTIONS

- You are responsible for following your treatment plan and instructions given by health care providers.
- You are responsible for keeping your appointment and for notifying the appropriate person if you are unable to keep your appointment.

REFUSAL OF TREATMENT

- You are responsible for your actions and resulting outcomes if you choose not to follow your treatment plan or follow instructions.

RESPECT AND CONSIDERATION

- You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise and the number of visitors. This includes being respectful of the property of other persons and the hospital.

_____ ____/___/____

Patient or Guardian Signature Date:

NTMC Health®

Authorization for Use or Disclosure of Health Information
Release of information

Patient Name:_____**DOB:**_____
Last 4 of SSN#:_____ Phone#:_____
Street Address:_____
City:_____State:_____Zip:_____
Release to Name:_____
Phone #:_____Fax#:_____
Street Address:_____
City:_____State:_____Zip:_____
Release From Name:_____
Phone #:_____Fax#:_____
Street Address:_____
City:_____State:_____Zip:_____

Information to be released:
From & To Dates:_____
_____Copy of complete records
_____Information related to HIV testing results
_____History & Physical/Consultation reports
_____Labs,X Rays,PFT's,Echo,Angio,OP reports
_____Other:specify_____

Purpose of disclosure of records:
__Changing physician __Second opinion
__Continuing care __Legal
__Workers comp. __Insurance
__School __my personal request

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, treatment of drug or alcohol abuse, mental illness, and/or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law. This authorization will expire One Hundred and Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition.

Signature: _____Relationship to patient:_____
Printed Name:_____Patient or Legal Representative Date:_____
Witness Signature:_____ Prepared by Signature & Date:_____

1902 Hospital Blvd. Gainesville, Tx 76240 940-612-8750

NTMC Health™
A Department of NTMC

MEDICAL AND PERSONAL HISTORY

Patient Name: _____ Date: ___/___/___ Sex: M / F _____ Race: _____ Date of Birth: ___/___/___

For what reason are you here today?

_____

_____

Please check conditions which you have had:

GENERAL
- ☐ Serious Infections (e.g., Pneumonia)
- ☐ Diabetes Mellitus
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer (Where?)

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT
- ☐ Glaucoma
- ☐ Allergies/ "Hay Fever"
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lungs
- ☐ Sleep Apnea

MUSCULOSKELETAL / EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (herniated disc)
- ☐ Back Pain (herniated disc)

LYMPHATIC/HEMATOLOGIC
- ☐ Thyroid Goiter
- ☐ Overactive Thyroid
- ☐ Underactive Thyroid
- ☐ Transfusions
- ☐ Anemia

GI/GU
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sexually Transmitted Infection

SKIN/BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

Doctor's Notes:

_____

_____

Please indicate when you last had any of the following preventative tests or services:

Year		Year		Year	
_____	Cardiac Angiogram	_____	Tetanus Vaccine	_____	Sigmoidoscopy
_____	Stress Test	_____	Hepatitis Vaccine	_____	Barium Enema
_____	Echocardiogram	_____	Bone Density Test	_____	Mammogram/Breast Exam
_____	Chest X-ray	_____	Prostate Cancer	_____	Pap Smear
_____	EKG	_____	Blood Test	_____	Date of last Physical Exam
_____	COVID	_____	Rectal Exam	_____	Other _____
_____	Flu Vaccine	_____	Colon Cancer Stool Test		
_____	Pneumonia Vaccine	_____	Flexible		

Doctor's Notes:

_____

_____

MEDICAL AND PERSONAL HISTORY (continued)

Please list any allergies or intolerance to drugs or other substances:

Please list the medications (or alternative medications) currently taken, their dosages, and how many times per day you take them:

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members (Mother, Father, Brothers, Sisters, or Children)

☐ Tuberculosis	☐ Diabetes Mellitus	☐ Kidney Disease	☐ Breast Cancer
☐ Emphysema	☐ Thyroid Disease	☐ Epilepsy	☐ Ovarian Cancer
☐ Heart Disease	☐ Anemia	☐ Neurological Disorder	☐ Colon Cancer
☐ High Blood Pressure	☐ Hemophilia	☐ Liver Disease	☐ Prostate Cancer
☐ Osteoporosis	☐ _____	☐ _____	☐ _____

Notes:

PERSONAL INFORMATION

Please write in or circle the information that applies to you.

Occupation:

Living Status:	**Diet:**	**Exercise:**
alone	none	none
with spouse	low fat	walking
with parent's	low chol	aerobics
assisted living	low carb	weightlifting
nursing home	vegetarian	_____days/week

Tobacco	**Alcohol**	**Illicit Drugs**	**Caffeine Drinks:**
Never/ past/ active	Never/ past/ active	never/ past/ active	never
Cigarette/ cigar/ pipe	liquor/ wine/ beer	cocaine/ marijuana	coffee/ tea / soda
Snuff/ dip/ chewing	_____drinks per	heroin/ amphetamine	How many_____cans/ cups
Start_____Stop_____	day/ week/ month	barbiturate/ LSD/ PCP	per day
Packs per day	AA/ Alcohol Rehab	IV Drug Abuse/ Drug Rehab	

Pain Medication Understanding

I understand that I am being treated for a medical condition that may require pain medication at NTMC Health clinic.

My provider will appropriately prescribe pain medication for my acute pain based on my resulting diagnosis and treatment plan. All pain medications are limited to TWO refills and will be taken as prescribed by my provider. If I need additional pain medication for effective management of chronic pain, I will be referred to a pain management physician.

In signing below, I consent to the care described above. I acknowledge that I have been given an opportunity to ask questions that I may have about my care and further treatment.

Patient Signature Date

Reviewed & Witnessed by (Staff Signature)

NTMC Health
A Department of NTMC

1902 Hospital Boulevard
Gainesville, Texas 76240
940-612-8750

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

03/03/2022

This Notice of Privacy Practices applies to the following organizations.

NTMC Health
A Department of NTMC

Leah Bayer Privacy officer, 1900 Hospital Boulevard, Gainesville Tx. 76240 940-612-8620