NTMC
North Texas
Medical Center

Patient's Full Name: _____Social Security #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____/____/_____ Age: _____ Sex: M/ F

Would you like access to your records through our patient portal? Would you like to sign up? Y / N

EMAIL: _____

Marital Status (Circle One): Single / Married / Divorced / Widowed

Phone Number (HOME): _____ (CELL): _____

Employer: _____ Work #_____

Race: Caucasian / African-American/ Other/Refuse Language: English / Spanish /Other/ Refuse

Ethnicity: Hispanic / Non-Hispanic/ Other/ Refuse

Spouse/ Parent/Guardian: _____ Birthdate: _____/_____/_____

Phone Number (HOME): _____ (CELL): _____

EMERGENCY CONTACT: _____ Phone # _____

Primary / Referring Physician: _____

Please list names of persons authorized to obtain your medical information: (Ex: spouse, children, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

X_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____

Witness Signature

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Medical Center

PATIENT INFORMATION SHEET

Do you have any food/ drug allergies? YES / NO Please list: _____

_____

_____

Please list all previous surgeries:_____

_____

_____

Pharmacy: _____

Please list all current medications you are taking: _____

_____

Do you take Aspirin? Yes/ No Dosage: 81 / 325 MG

Is there any family history of: Diabetes Yes / No Cancer: Yes / No

Heart Disease: Yes / No Other: Yes / No

Are you pregnant? Yes / No When was your last menstrual period? _____

Have you had ANY of the following problems? **Please circle YES or NO**

Heart disease, heart murmur, heart attack, congestive heart failure	YES / NO	Blood disease, leukemia, or lymphoma	YES / NO
High blood pressure, blood clots	YES / NO	Kidney disease, prostate problems, urinary infections	YES / NO
Liver disease, yellow jaundice, hepatitis	YES / NO	Gallbladder disease	YES / NO
Lung disease, asthma, COPD, emphysema, sleep apnea	YES / NO	Bowel problems, constipation, IBS, diarrhea	YES / NO
Stomach disease, ulcers, bloating, heartburn	YES / NO	Unexplained weight loss	YES / NO
Blood in stools	YES / NO	Thyroid problems	YES / NO
Diabetes	YES / NO	Tumors, growths, skin lesions	YES / NO
Seizures, convulsions, stroke	YES / NO	Have you ever taken steroids?	YES / NO
Anesthesia problems	YES / NO	Have you ever been seriously ill?	YES / NO
Do you have or have you had a drug or alcohol problem?	YES / NO	Do you smoke? (If Yes, how packs/day?) _____	YES/ NO

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____

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NEW PATIENT

Questions	Yes	No
Hysterectomy?	Total Partial (ABD) Radical (VAG)	
How many pregnancies?		
Drug or Food Allergies Reactions		
Have you ever used tobacco?	How much? When did you quit?	
Alcohol Consumption?	Quantity and Frequency:	
Have you ever used drugs?	What kind? If not currently using, when did you quit?	
Diabetes in the family?	Who? Mother or Father's side?	

Heart disease?	Who? Mother or Father's side?	
Cancer? Who and What kind of cancer?	Self: Mother: Father: Sister: Brother: Mother Side Father Side Grandmother: Grandfather: Aunt: Uncle: Cousin:	

SURGICAL SPECIALISTS OF NORTH TEXAS FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, OR DISCOVER.

INSURANCE

We are participants in the Medicare and Medicaid programs. Please be aware that some services provided may be non-covered and not considered reasonable and necessary under these programs. In such cases, the patient is responsible for the charges.

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 hospital stay to any other accounts for myself or a member of my family for who I am legally responsible. In the event there are no other accounts, a prompt refund will be made.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and 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 or customary rates.

MINOR PATIENTS

A parent or guardian must accompany a minor before non-emergency treatment can be administered.

I have read the Financial Policy, I understand and agree to the conditions of the Policy.

_____ _____

Signature of Patient or Responsible Party 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

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.

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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.*

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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