TEXAS MEDICAL INSTITUTE

PATIENT INFORMATION

Name: _____ Date: _____

Age: _____ Date of Birth: _____ S.S#: _____

Address:

_____

Street Name & Number City State Zip

Home Phone #: _____ Cellular #: _____ -Wk #: _____

How did you hear about our Office?_____

PLEASE ASK ABOUT OUR REFER A FRIEND PROGRAM

EMPLOYMENT INFORMATION

Employer Name: _____

Address: _____

Street Name & Number City State Zip

INSURANCE INFORMATION

Is this a work related injury? ☐ No * Go on to Insurance Company ☐ Yes Date of Injury: _____

Who may we contact to obtain you workers compensation information? i.e Risk Manger / Human Resources

Phone: _____ Contact Person:

INSURANCE COMPANY

Name:_____Phone #:_____

Policy#:_____Group #:_____

Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative _____

Policy Holder: Name:_____DOB: _____S.S#: _____

Employer Name: _____Phone #:_____

SECONDARY INSURANCE COMPANY INFORMATION

Name:_____Phone #:_____

Policy#:_____Group #:_____

Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative _____

Policy Holder: Name:_____DOB: _____S.S#: _____

Employer Name: _____Phone #:_____

AUTO ACCIDENT INSURANCE COMPANY INFORMATION / Date of Accident:_____

Name:_____Phone #:_____

Policy#:_____Claim #:_____

Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative _____

Policy Holder: Name:_____DOB: _____S.S#: _____

IN CASE OF AN EMERGENCY

Name: _____Phone#: _____

Address: _____

Street Name & Number City State Zip

Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative _____

MEDICAL HISTORY

What treatment have you already received for your condition?

□ Surgery: Was your surgery ____Successful ____Unsuccessful/who preformed this surgery? _____

□ Physical Therapy: Was your therapy ____Successful ____Unsuccessful/ where was it? _____

□ Chiropractic Services: Was your treatment ____Successful ____Unsuccessful/ where was it_____

□ Other _____ □ None

Name and address of the other Doctor(s) who treated you for your condition:_____

_____

_____

Date of Last: Physical Exam_____ Spinal X-Ray _____ Blood Test_____

Spinal Exam _____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Chicken Pox	□ Yes □ No	Liver Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Alcoholism	□ Yes □ No	Diabetes	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Emphysema	□ Yes □ No	Migraine Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Epilepsy	□ Yes □ No	Miscarriage	□ Yes □ No	Stroke	□ Yes □ No
Anorexia	□ Yes □ No	Fractures	□ Yes □ No	Mononucleosis	□ Yes □ No	Suicide Attempt	□ Yes □ No
Appendicitis	□ Yes □ No	Glaucoma	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Thyroid Problems	□ Yes □ No
Arthritis	□ Yes □ No	Goiter	□ Yes □ No	Mumps	□ Yes □ No	Tonsillitis	□ Yes □ No
Asthma	□ Yes □ No	Gonorrhea	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Gout	□ Yes □ No	Pacemaker	□ Yes □ No	Tumors, Growths	□ Yes □ No
Breast Lump	□ Yes □ No	Heart Disease	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bronchitis	□ Yes □ No	Hepatitis	□ Yes □ No	Pinched Nerve	□ Yes □ No	Ulcers	□ Yes □ No
Bulimia	□ Yes □ No	Hernia	□ Yes □ No	Pneumonia	□ Yes □ No	Vaginal Infections	□ Yes □ No
Cancer	□ Yes □ No	Herniated Disk	□ Yes □ No	Polio	□ Yes □ No	Venereal Disease	□ Yes □ No
Cataracts	□ Yes □ No	Herpes	□ Yes □ No	Prostate Problem	□ Yes □ No	Whooping Cough	□ Yes □ No
Chemical Dependency	□ Yes □ No	High Cholesterol	□ Yes □ No	Prosthesis	□ Yes □ No	Other: _____	
_____		Kidney Disease	□ Yes □ No	Have you ever had any nervous or mental illnesses?		□ Yes □ No	

Have you had psychiatric care? □ Yes □ No Have you received a medical discharge from the Armed Forces □ Yes □ No

EXERCISE	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Packs/day_____
□ Moderate	□ Standing	□ Alcohol	Drinks/week_____
□ Daily	□ Light Labor	□Caffeine Drinks	Cups/Daily _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____
			_____

Women Only: Are you pregnant? □Yes □No If yes Due Date: _____ # of Pregnancies: _____

Method of delivery: C-Section #_____Vaginal #_____Miscarriages #_____Other Female

Surgeries:_____

Injuries/Surgeries you have had Descriptions Date

Falls _____

Head Injuries _____

Broken bones _____

Dislocations _____

Surgeries _____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name:	_____	_____
_____		
Phone #:_____		

CONSENT TO TREATMENT

Date: _____

Patient Name: _____
(Print Name)

Omit any statement, which you do not wish to authorize by marking a line through the statement with your initial and date.

Consent to Treatment: I, as the patient or on behalf of the patient, do hereby consent to and authorize all medical, chiropractic and therapeutic treatment considered necessary or advised in the judgment of the physician on duty. I understand that no guarantees and/or assurances have been made as to the results which may be obtained.

Financial Agreement: I hereby guarantee payment for services at **Texas Medical Institute located at 6789 Camp Bowie; Fort Worth TX and/or 3304 S.W. Loop 820 Fort Worth TX and/or 8100 John Carpenter FWY. Dallas TX.** I understand that I will be held responsible for the court cost, legal fees, or agency fees which may be incurred in the collection of the account.

Assignment of Benefits: I hereby authorize all insurance companies to pay directly to **Texas Medical Institute** and any ancillary providers, any providers, any benefits and fees under my insurance policy or policies. I understand that this order does not relieve any of my obligations to pay the account or any balance that is not covered or paid by the insurance company carrier which may be my responsibility.

Release of Medical Information: I hereby consent and authorize **Texas Medical Institute's** Physicians and any ancillary providers, to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefit from my health insurance carrier.

Teaching Facility: I understand that **Texas Medical Institute** is affiliated with medical schools, nursing schools, and other academic programs and therefore resident physicians, interns, and students may be involved with my care.

Nurse Practitioners/Physician Assistant: I understand that **Texas Medical Institute** provides care by Physicians, Nurse Practitioners, and Physician Assistants. Nurse Practitioners and Physician Assistants are not physicians, but function under the supervision of a physician either directly or via protocols established by the physician.

I HAVE READ THE AUTHORIZATION, CONSENT, AND AGREEMENT AND I ACCEPT THE TERMS DESCRIBED ABOVE.

Patient Name: _____ Date:_____

Signature of Patient or Responsible Party _____

Relationship _____

Witness Signature _____ Date _____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-rays, and chiropractic modalities on myself (or on the patient names below for which I am legally responsible). All by which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the doctors of chiropractic named below.

Names and Addresses of Offices and Clinics

Texas Medical Institute
6789 Camp Bowie Blvd.
Fort Worth, TX 76116

Texas Medical Institute
3304 SE Loop 820
Fort Worth TX 76140

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Signature of Patient Date

Printed Name of Patient

Signature of Patient Representative (If minor or physically incapacitated)

Witness Date

Patient Record of Disclosures

HIPPA Privacy rule: **III. Other Uses and Disclosures of Health Information** We will not use or disclose your health information for any purpose other than those identified in this written Authorization. We cannot take back any uses or disclosures already made with your permission.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone #: _____
- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: _____

☐ Work telephone #: _____
- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: _____

☐ **Written Communication**
- ☐ Mail to my home address
- ☐ Mail to my work/office

☐ Other _____

_____ _____ _____

Patient Signature Date Print Name

Healthcare entities must keep records of PHI disclosures; information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosure for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to	1	Purpose	By Whom	2	3

1. Check this box if the disclosure is authorized
2. Print: T = Treatment Record; P = Payment Information; O = Other Healthcare provider
3. How was disclose made: F = Fax; P = Phone; E = E-mail; O = Other

Standard Authorization Form
To Use or Disclose Protected Health Information (PHI)

Patient Name:_____ Date: _____
Address: _____ SS#:xxx-xx- __ __ __ __
_____ D.O.B: _____

Receive Records From:

_____
_____
_____

Release Records To:
Texas Medical Institute
☐ P: 817-615-8633 Fax: 817-615-8635
☐ P: 817-731-2102 Fax: 817-731-2157

Please send a copy of my records as indicated for date(s) of Treatment: _____

Specifically:

☐ History & Physical	☐ Nursing Notes	☐ EEG/EKG/CAT Scan
☐ Discharge Summary	☐ Social Serv. Notes	☐ MD Orders
☐ Operative Report	☐ Laboratory	☐ other please specify:
☐ MD Progress Notes	☐ Radiology	_____
		_____

Purpose for releasing medical information_____
_____

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

_____
Date

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

_____
Date

NOTICE OF PRIVACY PRACTICES

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.

Texas Medical Institute uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this notice.

- **Treatment, Payment, Health Care Operations Treatment**

  We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of another health care professional (HCP). When we refer you to another healthcare HCP, we will share some or all of your medical information with them to facilitate the delivery of care. At times, we may request that other HCP share your medical information with us.

- **Payment**

  We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or those responsible for receiving and paying the claim. The form will contain medical information necessary to pay the claim, such as a description of the medical service provided to you.

- **Health Care Operations**

  We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may ask another physician to review charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

- **Disclosures That Can Be Made Without Your Authorization**

  There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. These situations are outlined in the next six sections. In other instances we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization. Examples of situations where it is necessary for you to provide specific authorization are for employment related physicals or release of medical records to attorneys.

- **Public Health, Abuse or Neglect, and Health Oversight**

  We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury to a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled. We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and

inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

- **Legal Proceedings and Law Enforcement**

  We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

  If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

  - Is released pursuant to legal process, such as a warrant or subpoena;
  - Pertains to a victim of crime and you are incapacitated;
  - Pertains to a person who has died under circumstances that may be related to criminal conduct;
  - Is about a victim of crime and we are unable to obtain the person's agreement;
  - Is released because of a crime that has occurred on these premises; or
  - Is released to locate a fugitive, missing person, or suspect.

  We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

- **Workers' Compensation**

  We may disclose your medical information as required by the State Workers' compensation law.

- **Military, National Security and Intelligence Activities, Protection of the President**

  We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

- **Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors**

  When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

- **Required by Law**

  We may release your medical information where the disclosure is required by law.

- **Your Rights Under Federal Privacy Regulations**

  The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

- **Requested Restrictions**

  You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. In fact, The Facility will not agree to changes to this notice or restrictions placed on disclosure of protected health information. If such restrictions are a requirement for you we recommend you not initiate a treatment relationship with The Facility. To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the

request to the address and person listed at the end of this document. You should not consider that your request has been granted until such time as you receive written confirmation from us agreeing to your restriction. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

- **Receiving Confidential Communications by Alternative Means**

  You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

- **Inspection and Copies of Protected Health Information**

  You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. State law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to inspect your records to the person listed below. For copies of medical records, please contact our Medical Records Department. We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:
  - Includes psychotherapy notes.
  - Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
  - Is subject to the Clinical Laboratory Improvements Amendments of 1988.
  - Has been compiled in anticipation of litigation.

  We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee. The State Board has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the state board will be charged.

- **Amendment of Medical Information**

  You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:
  - Wasn't created by this practice or the physicians here in this practice.
  - Is not part of the Designated Record Set.
  - Is not available for inspection because of an appropriate denial.
  - If the information is accurate and complete.

  Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

- **Accounting of Certain Disclosures**

  The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional

requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

- **Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits**

  We may contact you by mail, email, telephone, and leave messages, on voicemail or message machines or with another person to provide appointment reminders, information about treatment alternatives, to follow up on your care after a visit or other health-related benefits and services that may be of interest to you.

- **Complaints**

  If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

  Office of Civil Rights
  U.S. Department of Health and Human Services
  200 Independence Ave S. W.
  Room 509 F HHH Building
  Washington, DC 20201

- **Our Promise to You**

  We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

- **Questions and Contact Person for Requests**

  If you have any questions or want to make a request pursuant to the rights described above, please contact the Privacy Officer of Texas Medical Institute.

This notice is effective on: 5/11/2012

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office.

Your Protected Health Information Rights

Although your health record is the physical property of Texas Medical Institute, you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of the Protected Health Information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances, If you are denied access to Protected Health Information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Amend: If you feel that the Protected Health Information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by Texas Medical Institute. Any request for an amendment must be sent in writing to the Privacy Officer. We may deny your request for an amendment and if this occurs, you will be notified of the reason for your denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your Protected Health Information for the purposes other than treatment, payment or heath care operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the Protected Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or a friend. Any request for a restriction must be sent in writing to the Privacy Officer.

- We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. Texas Medical Institute will grant reasonable request for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by Texas Medical Institute and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to reasoned to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To exercise your rights, please obtain the required forms from the Privacy Officer.

Changes to this Notice

We reserve the right to change this notice and the revised or change notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted at Texas Medical Institute and on our web site and include the effective date. In addition, each time you register at or are admitted to Texas Medical Institute for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Texas Medical Institute by following the process outline in the HIPAA manual. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

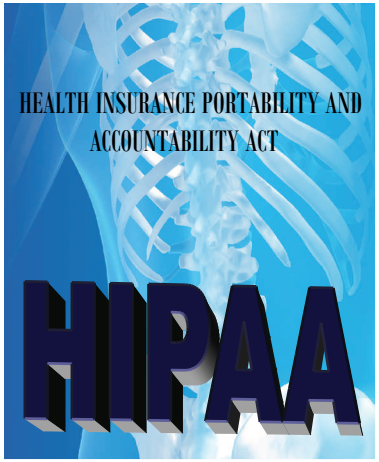
Other uses of Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose Protected Health Information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose Protected Health Information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

TEXAS MEDICAL INSTITUTE

TEXAS MEDICAL INSTITUTE

Notice of Privacy Practices



THIS NOTICE DESCRIBES HOW HEALTH INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFROMATION. **PLEAS REVIEW IT CAREFULLY.**

If you have any questions about this notice please contact the Texas Medical Institute Privacy Officer.

Privacy Officer
Dr. Bobbie Thompson, DC

Each time you visit Texas Medical Institute a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by Texas Medical Institute, whether made by Texas Medical Institute personal, agents of Texas Medical Institute, or your personal doctor.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information and provide you a description of your privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Protected Health Information about you. The following categories describe examples of the way we use and disclose protected health information.

For Treatment: We may disclose Protected Health Information about you to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations; for example: On occasion it may be necessary to seek consultation regarding your condition from other health care providers associated with Texas Medical Institute. It is also our policy to provide a substitute healthcare provider, authorized by Texas Medical Institute to provide assessment and/or treatment to our patients, without advanced notice in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation.

For Payment: We may use and disclose Protected Health Information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

Workers' Compensation: We may disclose your protected health information as necessary to comply with State Workers' Compensation Laws.

We may also use and disclose Protected Health Information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our service;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To contact you as part of fund-raising efforts, unless you elect not to receive any such communications;
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Emergencies: We may disclose your Protected Health Information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or death.

Public Health: As required by law, we may disclose your Protected Health Information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information has approved their research and granted a waiver of the authorization requirement.

Law Enforcement/Legal Proceedings: We may disclose Protected Health Information for law enforcement purposes as required by law or in response to a valid subpoena.

Deceased Person: We May disclose your Protected Health Information to coroners or medical examiners.

Organ Donation: We may disclose your Protected Health Information to organizations involved in procuring, banking, or transplanting organs and tissues.

Specialized Government Agencies: We may disclose your Protected Health Information for military, national security, prisoner and government benefits purposes.

Change of Ownership: In the event that the facility is sold or merged with another organization your Protected Health Information/record will become the property of the new owner.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have been given a copy of this facility's "Notice of Privacy Practices", which describes how my health information is used and shared. I understand that Texas Medical Institute has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Privacy Officer of this facility at any time.

As required by the Privacy Regulations, NAME OF STAFF MEMBER from Texas Medical Institute has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

Requests:

- ☐ I want to file a "Request for Restriction" of my protected health information.
- ☐ I want to file a "Request for Alternative Communications" of my protected health information.
- ☐ I want to object to the following in the "Notice of Privacy Practices":

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature:	Date:
Print Your Name:	

OFFICE USE ONLY

Received By:	Date:

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

This form is to be maintained in the HIPAA Administrative Compliance Manual and is to be updated by the Privacy/Security Officer as necessary. A copy of this form shall also be maintained in the patient's file.