Houston County Family Medical Clinic
REGISTRATION FORM (Please Print)

Today's date:	Email Address:		

PATIENT INFORMATION

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.	Last Name:	First:	Middle:
Birth Date:	Age:	Sex:	SS#:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed			
Address City State Zip:		Cell Phone:	Office phone :
Home Phone:		Occupation:	Employer:
Pharmacy:		Phone:	City:
Race: circle one American Indian or Alaskan Native / Asian / White Black or African American / Native Hawaiian or other Pacific Island Not Provided		Ethnicity: circle one Hispanic or latino / Not Hispanic or latino / Not provided	Language spoken:

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No	Other Coverage:		
Person Responsible for bill:	Address:	Phone:	
Occupation:	Employer:	Employer address:	Employer phone:
	Please give insurance card and driver's license to receptionist to make a copy.		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone:	Work phone :

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the health care provider or physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required for processing my claims.

I also give my permission for Houston County Family Medical Clinic to download any electronic prescriptions and medication history that may help in my medical treatment. I also confirm that I have been advised that this practice prescribes medications, via e-prescribing, according to state regulations.

_______________________________ _______________

Patient/Guardian signature *Date*

NO-SHOW appt policy:

We require 24 hour notice for appt cancelation or a $25 fee may be assessed

Houston County Family Medical Clinic

Patient Name:____ Date: _____________________

Reason for today's visit: (check appropriate box(s) below)

_____Recent illness (list all symptoms associated with recent illness) ________________________

____

_____Routine follow up

_____ 1 week follow up

_____1 month follow up

_____Medication refills (list medications & vitamins)

____

____

____

____

____

_____Yearly Physical

_____ Yearly Medicare Wellness Exam

Preferred Pharmacy____

Patient Name:__________________________________

DOB_______________ **Date of visit:**______________

Medical history: list all chronic illnesses (none)

____
____
____
____
____

Surgical history: list all past surgeries/procedures

Surgery/Procedure (none) **Date**

_________________________________/____________
_________________________________/____________
_________________________________/____________
_________________________________/____________
_________________________________/____________
_________________________________/____________

Family history: list any significant family illnesses & relation

Relation **Problem/disease**

____________________/___________________________
____________________/___________________________
____________________/___________________________
____________________/___________________________
____________________/___________________________

Social history: circle one

Tobacco: Current smoker/past smoker/never

Amount _____________________

Alcohol: Currently drinks/past drinker/never

Amount _____________________

Medication history: list all current medications

Name of drug (none) **dosage** **1 a day/2 a day/3 a day, etc**

___________________/________/___________________
___________________/________/___________________
___________________/________/___________________
___________________/________/___________________
___________________/________/___________________
___________________/________/___________________
___________________/________/___________________
___________________/________/___________________
___________________/________/___________________

Drug allergies: (none)

Name of drug **Reaction**

__________________________/____________________
__________________________/____________________
__________________________/____________________
__________________________/____________________

Food & Environmental allergies: (none)

Name of allergen (none) **Reaction**

__________________________/____________________
__________________________/____________________
__________________________/____________________
__________________________/____________________

Immunization history: list immunizations and date given if available

Immunization **Date given**

___________________________/___________________
___________________________/___________________
___________________________/___________________
___________________________/___________________
___________________________/___________________
___________________________/___________________

List additional immunizations on back

(If the following information has already been given please skip)

I give consent to retrieve medication list from any approved entity:_____________ **(initial here)**

Preferred Pharmacy:____________________________

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.

This practice 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 practice also utilizes **electronic health records**. 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 below.

Natalie Bachynsky, PhD, FNP-C, APRN – Privacy Officer

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 a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician/ provider to facilitate the delivery of care.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer. The form will contain medical information, such as a description of the medical service provided to you that your insurer needs to approve payment to us.

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. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical & nursing students and licensing.

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. In other situations 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.

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 by 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 health care providers 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 your 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 Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

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.

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 below.

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. Texas 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 the person listed below.

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 Texas State Board of Medical Examiners (TSBME) 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 TSBME 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 providers 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 telephone, secure text or mail to provide appointment reminders, information about treatment or test results. ***It is also in our practice to leave messages on answering machines or voice mail. Please advise the Privacy Officer if you do not agree to this specific type of release.***

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:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

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:

Natalie Bachynsky
1501 E. Loop 304, Suite 50, Crockett, TX, 75835
phone: 936-544-7223
fax: 936-544-8083

This notice is effective on the following date: _____January 27, 2020._____

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 where it can be seen.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed 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.

____
Signature of Patient of Personal Representative

____
Date

____
(Please Print) Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

I hereby give permission to discuss my medical conditions with the follow person(s):

_________________________________ Name	______________________ Relationship
_________________________________ Name	______________________ Relationship
_________________________________ Name	______________________ Relationship

____
Signature of Patient of Personal Representative

This authorization will be in effect until otherwise noted or indicated.

Electronic Communications Consent Form

Patient-Healthcare Provider Electronic Communication Agreement

The patient agrees that, all electronic communications will be sent either through the patient portal or secure email. This is to provide an opportunity to communicate with your healthcare provider relative to issues that are **non-emergent, non-urgent or non-critical.** Electronic Communications are not a replacement for the interpersonal contact that is the very basis of the doctor-patient relationship.

General Considerations

Your Healthcare Provider will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. Your Healthcare Provider has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended (HIPAA.)

Standard email services (including, but not limited to Yahoomail, Outlook.com, and Gmail) are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals.

Transmitting email that contains protected health information through an email system that is not encrypted do not meet and electronic communication security guidelines as required by HIPAA. Any electronic communications sent from this office will be sent via the patient portal, secure email or secure text message. I understand that an email or text will not be sent via non secure method, and any such correspondence will be reported to Houston County Family Medical Clinic.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with Houston County Family Medical Clinic.

I understand that I can withdraw this consent authorizing my healthcare provider to communicate with me via Electronic Communications at any time by written notification to Houston County Family Medical Clinic.

I release and hold harmless the healthcare provider and their staff, employees, affiliates, agents, officers, directors and shareholders from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses, of any kind that I may have resulting from Electronic Communications between the healthcare provider and me based on this authorization given to th healthcare provider to communicate with me via Electronic Communications.

Having been informed of the risks associated with Electronic Communications, I still desire to communicate with the healthcare provider via electronic communications. I hereby authorize the healthcare provider to engage in Electronic Communication with me.

Patient Signature ______________________Patient Representative Signature (if not patient)________________

Date: ________________

HOUSTON COUNTY FAMILY MEDICAL CLINIC

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better information about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Houston County Family Medical Clinic utilizes a nurse practitioner to provide medical care. Natalie Bachynsky, PhD, FNP-C, APRN (nurse practitioner) has a collaborative practice agreement with James M. Cochran, MD (supervising physician). Under this agreement, Natalie Bachynsky, PhD, FNP-C, APRN (nurse practitioner) may perform the following:

1. Take, evaluate, and record comprehensive health histories
2. Perform comprehensive physical examinations required to evaluate health status and acute and/or chronic medical problems
3. Order, conduct, and interpret appropriate laboratory, screening studies, tests, and diagnostic procedures used to assess and diagnose problems, and establish management/treatment plans
4. Diagnose, treat, and manage acute episodic and chronic illnesses, minor traumas, and behavioral/psychological problems
5. Initiate consultation requests and work in collaboration with specialists and other health professionals as appropriate
6. Teach, counsel, and advise students about current health status, illness(es), and health-promotion and disease prevention activities
7. Prescribe non-pharmacological therapies and pharmacological agents (medications) to include scheduled or controlled substances within the scope of practice for a family nurse practitioner

DISCLAIMER: Among its services, Houston County Family Medical Clinic utilizes screening tests, including certain blood tests, which are a method of identifying individuals who are at risk for developing several common medical problems. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic, and they do not constitute a complete exam. Houston County Family Medical Clinic cannot assume the responsibility for payment of medical care received or performed outside Houston County Family Medical Clinic, including labs and/or other diagnostics, etc., even if such care was ordered by Houston Family Medical Clinic health care providers.

GENERAL CONSENT: I give permission to Houston County Family Medical Clinic, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED UNDERSTANDING: I understand that no warranty or guarantee has been made to me as to

the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical and Social Service Records may be released to representative of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding sources for the purposes of determining contract compliance with Federal/State law and regulations.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the service have been answered to my satisfaction.

SIGNATURES: Fill blank lines with "NA" if not applicable.

SECTION I:

Patient's Name ______________________________________

Person Authorized to Consent

(if not patient) ______________________________ Relationship ____________________________

Signature ____ Date _____________________________

SECTION II:

Witness Name: _____________________________ Signature: ____________________________
(Clinic Staff)

Date ___________________________

*Translated into ____________________________/ Read to me by

____

Signature of Person translating or reading consent to patient:

____

Date: ________________________________

Medical Records Release Form

Requesting records from the following provider/physician/facility/entity:

____

Address: ____

Phone number: _________________________Fax number: ____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my records, or a summary or narrative of my protected health information, to the provider/physician/facility/entity listed below.

The information you may release subject to this signed release form is as follows:

- ☐ Care Plan
- ☐ Complete Records
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ Lab Reports
- ☐ History & Physical
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Radiology Reports
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Other (please specify below)

____

____

____

____

Release my protected health information to the following provider/physician/facility/entity and/or those directly associated in my medical care:

Natalie Bachynsky, PhD, FNP-C, APRN
Houston County Family Medical Clinic
1501 E. Loop 304, Suite 50, Crockett, TX 75835
(ph) 936-544-7223; (fax) 936-544-8083

The purpose/reason for this release of information is:

☐ Continuation of medical care
☐ Other (please specify) ____

____
Patient Name

____
Patient Date of Birth or Social Security Number

____
____
Patient Address

____
Patient Phone Number

____
Signature of Patient or Personal Representative

____
Printed Name of Patient Representative

____
Description of Personal Representative

____
Date

01/27/2020