PAMPA MEDICAL GROUP
NEW PATIENT QUESTIONNAIRE

Name: _____ D.O.B. _____

Address: _____

Home Phone: _____ Cell: _____

Health Insurance: _____

Name of last Primary Care Doctor: _____

Reason for change: _____

Date of last visit with your last primary care provider: _____

Please list any medical conditions:

_____

_____

Please list all medications you currently take or have taken along with date last filled and prescribing physician:

_____

_____

_____

**Please use back of form if needed

Tobacco use: Yes _____ No _____

Type: _____ Number of Years: _____

Usage per Day: _____

I certify that the above information is accurate and complete. I understand that inaccurate, false, or missing information may constitute dismissal from this practice.

Signature_____ Date_____

PAMPA
MEDICAL GROUP

Adult New Patient Questionnaire

Date completed: ____/____/____

PERSONAL INFORMATION

Name: _____ Date of birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

What is your primary language? _____ Requesting to see which provider: _____

Do you have special needs in any of the following areas?

❑ Reading ❑ Vision ❑ Hearing ❑ Mobility (e.g., wheelchair, walker, etc.) ❑ Communication (e.g., need for a translator)

EMERGENCY CONTACT

Who do you want to designate as your emergency contact?

Name: _____
Relationship: _____
Address: _____
City, State: _____
Phone Number: _____

SHARING INFORMATION

I authorize the following listed person/persons to communicate with Pampa Medical Group on my behalf and I understand that the communication may include my medical information. :

_____ _____

(Leave blank if you do not wish anyone to have access to your medical information)

ALLERGIES List medication allergies and the type of reaction you had. ❑**I have no drug allergies**

_____ _____

_____ _____

MEDICATIONS List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed. ❑**None**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name: _____

YOUR MEDICAL CONDITIONS (check all that apply)

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety or panic attacks
- ❑ Arthritis
- ❑ Asthma
- ❑ Back or neck injury
- ❑ Cancer
- ❑ Clotting disorder
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes mellitus
- ❑ Emphysema/COPD
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ Glaucoma
- ❑ Heart murmur
- ❑ HIV/AIDS
- ❑ High cholesterol
- ❑ Hypertension/high blood pressure
- ❑ Kidney disease
- ❑ Heart attack
- ❑ Nerve/muscle disease
- ❑ Osteoporosis
- ❑ Seizures
- ❑ Sickle cell anemia
- ❑ Substance abuse
- ❑ Thyroid disease
- ❑ Tuberculosis

Details/Other: _____

Any Recent travel outside of the US? _____

SURGICAL HISTORY (check all that apply)

- ❑ Appendectomy
- ❑ Brain surgery
- ❑ Breast surgery
- ❑ CABG
- ❑ Cholecystectomy
- ❑ Colon surgery
- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Thyroid surgery
- ❑ Lung surgery
- ❑ C-section
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Hernia repair
- ❑ Hysterectomy
- ❑ Joint surgery
- ❑ Bunionectomy
- ❑ Varicose vein surgery
- ❑ Prostate surgery
- ❑ Weight reduction surgery
- ❑ Small intestine surgery
- ❑ Spine surgery
- ❑ Tubal ligation
- ❑ Valve replacement
- ❑ Vasectomy
- ❑ Vascular surgery
- ❑ Cardiac stent
- ❑ Bladder surgery

Have you ever had a blood transfusion? ❑ No ❑ Yes, approximate dates: _____

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other cancer(s)	Diabetes	Heart disease	High cholesterol	Hypertension	Mental illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other family history: _____

HABITS AND ACTIVITIES

Do you use tobacco? ❑ No ❑ Yes, what form? _____ How much? _____ For how long? _____

❑ In the past How many years ago did you quit? _____

❑ Have you tried to quit? ❑ No ❑ Yes Would you like to quit? ❑ No ❑ Yes

Do you drink alcohol? ❑ No ❑ In the past ❑ Yes, how many drinks per week? _____

Do you, or have you ever, used recreational drugs? ❑ No ❑ Yes, describe: _____

Do you get regular exercise? ❑ No ❑ Yes, what kind of exercise? _____

lame: _____

IMMUNIZATIONS

Vaccination	Approximate Year	Never
Pneumonia (pneumovax)	_____	❑
-Prevnar 13	_____	❑
-Prevnar 20	_____	❑
Tetanus booster (Tdap)	_____	❑
TB skin test (PPD)	_____	❑
Hepatitis B vaccine	_____	❑
Hepatitis A vaccine	_____	❑
Varicella (chicken pox)	_____	❑
Shingles Vaccine	_____	❑
RSV Vaccine	_____	❑

PREVENTIVE CARE

Test or Procedure	Date and Result	Never
Colonoscopy	_____	❑
Bone density test (DXA)	_____	❑
Digital Rectal Exam	_____	❑
Pap smear	_____	❑
Mammogram	_____	❑

List any abnormal screening test results (e.g. polyps, breast biopsies, etc.): _____

_____

SEXUAL HISTORY

My sexual partners have been: ❑ Male ❑ Female ❑ Both ❑ Never Sexually Active

Have you had more than one sexual partner in the past year? ❑ No ❑ Yes

Have you ever had a sexually transmitted disease? ❑ No ❑ Yes, what and when? _____

GYNECOLOGICAL AND OBSTETRIC HISTORY (Women only)

How many times have you been pregnant? _____ Live births? _____ Miscarriages? _____ Abortions? _____

Do you use contraception? ❑ No ❑ Yes, what kind? _____

What was your age at first menses? _____ Menstrual periods: ❑ Regular ❑ Irregular ❑ Menopausal

Age at menopause? _____ Do you have hot flashes or other symptoms (specify)? _____

Any gynecological conditions or problems? _____

OTHER HEALTH ISSUES

In the past year, have you had any major life changes or stresses that you feel have impacted your overall health?

No Yes, describe: _____

Name: _____

Other Physicians or Providers that you go to:

Name: of Provider:_____ **City:**_____ **Specialty:**_____

Name: of Provider:_____ **City:**_____ **Specialty:**_____

Name: of Provider:_____ **City:**_____ **Specialty:**_____

Name: of Provider:_____ **City:**_____ **Specialty:**_____

Name: of Provider:_____ **City:**_____ **Specialty:**_____

Insurance Coverage

Medicare Card Number: _____

Medicare Part D: _____

Prescription Card Carrier: _____

Medicaid Card Number: _____

Insurance Carrier: _____

MEDICAL RECORDS RELEASE

If you have not already done so, please sign a medical record release form so that your current medical providers can forward a copy of your medical records to Pampa Medical Group.

For more information about transferring your medical records to Pampa Medical Group, contact our office at 806-665-0801.

SUBMITTING YOUR FORM

Submission Instructions

Please fill out this form completely and returned it to the Pampa Medical Group office.

1) You can fax the form to the Pampa Medical Group office at 806-665-8503.
2) Hand deliver the form to the Pampa Medical Group office.
3) Mail the form to:

Pampa Medical Group
3023 Perryton Pkwy #101
Pampa, Tx 79065

Pampa Medical Group

Date_____ **Primary Physician**_____ **Pharmacy** _____

PATIENT NAME _____
Last First Middle Initial DATE OF BIRTH

MAILING ADDRESS_____
City State Zip

PHONE_____ _____ _____ **Marital Status**_____
Home Cell Work

SOCIAL SECURITY #_____**EMPLOYER**_____

Male_____ **Female**____ **RACE**_____ **PREFERRED LANGUAGE**_____

RESPONSIBLE PARTY

NAME _____**Relationship to Pt**_____
Last First Date of Birth

ADDRESS_____
Street City State Zip

Phone _____ _____ _____ **Marital Status**_____
Home Cell Work

SOCIAL SECURITY #_____**EMPLOYER**_____

EMERGENCY CONTACT_____
Name Phone #

INSURANCE
PRIMARY _____**SECONDARY**_____

****PLEASE GIVE RECEPTIONIST COPY OF INSURANCE CARD***

DO YOU HAVE AN ADVANCED DIRECTIVE? Y OR N IS IT ON FILE WITH US? Y OR N

CLINIC POLICY

All Professional Services Rendered are charged to the patient. Necessary Forms will be completed to help expedite Insurance Carrier Payments however the patient is responsible for all fees regardless of insurance coverage.
All payments will be due at time of service unless arrangements are made in advance. Missing a scheduled appointment, considered a no-show, will incur a fee of $25.00 and must be paid prior to next appointment.

PATIENT AUTHORIZATION

-I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the provider of Pampa Medical Group, their staff and designees, as may in their professional judgment, be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures
-I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of an original. I have received a copy of office policies and agree to abide by them.
-I authorize Pampa Medical Group to apply for benefits on my behalf for services rendered by them or by this order. I request payment from my insurance be paid directly to Pampa Medical Group.
-I certify that the information I have reported about my insurance coverage is correct and I will pay any unpaid balance by my insurance company within 10 days of receiving a bill from Pampa Medical Group.

Pampa Medical Group may leave messages on my Home Phone _____Yes _____NO Work Phone _____Yes _____NO

Signature of
PT/Parent/Guardian_____Date_____

PAMPA MEDICAL GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of this practice's Notice of Privacy Practices. This Notice describes how this practice may use and disclose my information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY MEMBER OR OTHERS

I, _____hereby Authorize Pampa Medical Group to release information regarding my health, care and treatment to the following individuals.

NAME **RELATIONSHIP**

_____

_____

_____

PATIENT SIGNATURE **DATE**

ADVANCED DIRECTIVE

Do you have an Advanced Directive? _____ Yes _____ No

If Yes, what is your advanced directive? (Please provide copy if available for your records)

_____

If No, would you like more information about your advanced directive options?
_____ Yes _____No

PATIENT PORTAL AUTHORIZATION ON THE WEB

Pampa Medical Group offers the opportunity to use the power of the web to track most important aspects of your healthcare through our office. The Patient Portal enables patients to communicate with our staff easily, safely and securely via the internet.

Patients are sent, via email, a secure User ID and Password, enabling them to access our secure Patient Portal to view their health records, including lab and diagnostic test results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal.

In order to provide you access to the Patient Portal, please provide us your email address or select one of the boxes below:

EMAIL ADDRESS:_____

_____I do not have an email address

_____I do not want access to the Patient Portal

_____I do not want to share my email address

Advanced Practice Nurse and Physician Assistant - Consent For Treatment

This facility has on staff an advanced practice nurse and/ or physician assistant.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse or physician assistant for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse or physician assistant and request to see a physician.

NAME:_____
DATE:_____

SIGNATURE:_____WITNESS: (optional)_____

TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Female ☐ Male Telephone ___-___-____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____ Printed Name

_____ Date _____ Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac DC
Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.
DO NOT fax to ImmTrac2. **Retain this form in your client's record.**

Pampa Medical Group

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at _____

in the city of _____ in the state of _____ hereby authorize:

Name of Doctor: _____

Address: _____

Phone: _____ Fax: _____

To disclose the following specific medical information by mail, fax, or pick-up to:

Pampa Medical Group
3023 Perryton Parkway, Suite 101
Pampa, TX 79065
Phone: 806-665-0801 Fax: 806-665-8503

From the Health Records of:

Name: _____ Date of Birth: _____

Address: _____

City, St., Zip: _____ Phone: _____

My authorization extends only to those data elements/ documents initialed below:

_____ Complete Record	_____ Billing Records	_____ Progress Notes
_____ History and Physical	_____ Radiology Reports	_____ Radiology Films
_____ Consultation Reports	_____ Physicians Orders	_____ Laboratory Reports
_____ Record of visit for specific date or dates: _____		_____ Mental Health Records
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV information		_____ Hepatitis Information

_____ Other (Must be specific) _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior authorization, except otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available upon request.
4. Pampa Medical Group of Pampa, its employees, officers, and physicians are hereby released from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient or Authorized Representative and Relationship Date

_____

Printed Name

Patient Rights & Responsibilities

WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RESPONSIBILITY TO:

Treat the staff with consideration, respect and dignity.

Understand that your life-style does affect your health.

Take an active part in your health care.

Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the Medical Provider.

Observe facility rules and regulations that are for the safety and consideration of all patients and staff.

Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.

Report whether you understand a contemplated course of action and what is expected of you.

WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RIGHT TO:

Be treated with consideration, respect and dignity;

Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand;

Have privacy during case discussion, counseling & treatment;

Review your records in the presence of a healthcare professional;

Know the name and qualifications of staff providing your care;

Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand;

Expect that all services, treatment and counseling techniques will take place with your informed consent;

Participate in referral planning;

Have access to the patient comment procedure;

Refuse to participate in research.

Have another individual present in the exam room with you, if you so desire.

PAMPA MEDICAL GROUP
NOTICE OF PRIVACY PRACTICES

Dear Patient:

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

INTRODUCTION

At Pampa Medical Group, we are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective (DATE) and applies to all Protected Health Information as defined by federal regulations.

WHAT IS PROTECTED HEALTH INFORMATION?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

UNDERSTANDING YOUR MEDICAL RECORD/PROTECTED HEALTH INFORMATION

Each time you visit Pampa Medical Group a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication with other health professionals involved in your care.
- Legal document outlining and describing the care you received.
- A tool that you, or another payor (your insurance company) will use to verify that services billed were provided.
- A source for medical research.
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards.
- A source of data for planning and/or marketing.
- A tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how your health information is used help you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We May Use or Disclose Your Health Information:

For Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

For Payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you. Note: If you paid out of pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item of service, you have the right to ask that your 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 our practice will honor that request. You must promptly notify us of this request.

For Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of Pampa Medical Group. For example: Information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality of healthcare services.

For Appointment Reminders, Treatment Alternatives, and Health-related Benefits and Services. We may use and disclose health information to contact you to remind you that you have an appointment with us. We also may use and disclose health information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

For Business Associates. In some instances, we have contracted separate entities to provide services on our behalf. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than to accomplish the task they were contracted to perform.

For Research/Teaching/Training. We may use your information for the purpose of research, teaching, and training. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Protected Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Protected Health Information.

For Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally-required notices of unauthorized access to or disclosure of your health information.

To Coroners, Medical Examiners, and Funeral Directors. We may disclose Protected Health Information to a coroner medical examiner, or funeral director so that they can carry out their duties.

For Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in tissue donation and transportation.

For Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Heath Information to the appropriate foreign military authority if you are a member of a foreign military.

For Workers' Compensation. We may release Health Information for Workers Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

As Required by Law. We will disclose Protected Health Information when required to do so by international, federal, state or local law.

For Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

For Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

For Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to informer you about the request or to obtain an order protecting the information requested.

For Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under that custody of a law enforcement official, we may release Protected Health Information to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made on to someone who may be able to prevent the threat.

Uses and Disclosures where You Have an Opportunity to Object and Opt Out:

For Individuals Involved in Your Care or Payment for Your Care. Due to the nature of our field, we will use our best judgement when disclosing health information to family members, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

For Disaster Relief. We may disclose your Protect Health Information to disaster relief organizational that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such disclose whenever possible.

For Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Written Authorization is Required for the Following Uses and Disclosures:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

For Others Uses and Disclosures. Disclosure of your Protected Health Information or its use for any purpose of those listed above may or may not require your specific written authorization, if you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization, However, your decision to revoke the authorization with not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

OUR RESPONSIBILITIES

Pampa Medical Group is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

We will not share or disclose your health information without your authorization, except as described in the notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to an electronic copy of your medical record(s).
- The right to a summary or explanation of your medical records(s).
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive notice of a breach.
- The right to receive a printed copy of this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practice of Pampa Medical Group, please contact:

Jenifer Richards
Pampa Medical Group
3023 Perryton Parkway, Suite 101
Pampa, TX 79065
806-665-0801

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Officer, or, you may file a complaint with the Office of Civil Rights (OCR), U.S. Department of Health and Human Services. **There will be no retaliation for filing a complaint with either the practices Privacy Officer or with the Office of Civil Rights.**

To file a complaint with OCR, you may:

(1) Mail it to:
Secretary of the U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201;
(2) Call (202) 619-0257 (or toll free (877) 696-6775
(3) Or visit the OCR website, www.hhs.gov/ocr/hipaa/, for more information on the options listed above, or for electronic filing option.

Pampa Medical Group

Office Policies

Making an Appointment

Request an appointment: call our office to schedule your next visit.

- If it's been a year since your last check-up, call for a complete preventive care exam. Children should be scheduled for periodic well-child exams to monitor their growth and development and keep up with their immunizations.
- If you need to schedule allergy shots, blood draws, or blood pressure checks, please contact the office for the best available times.
- Disease management is one of our most important ways of keeping you healthy. For our patients with diabetes, asthma, high blood pressure, and heart disease, regularly scheduled visits are very important.
- If you have made the appointment for yourself, please don't ask us to see another family member or friend during your appointment time. We would be happy to schedule an appointment for them at another time.
- If your address, phone number, or insurance has changed, please let us know while scheduling your appointment so that we can have the most up-to-date record for you.

When You Arrive

Please check in and update your information.

- Plan to arrive 15 min before your appointment time to complete your registration and insurance information.
- When you first arrive, please register with the receptionist.
- Please bring your insurance cards and a valid photo ID to your appointment.
- Self-pay patients (those with no insurance); please be prepared to pay for your visit at the time of service.
- Please be courteous. We ask that you do not bring food or drinks into the waiting room. Once you are in the exam room, please turn off your cell phone.

When You Are Late For an Appointment

Your time is valuable - and so is the doctor's

- Please be prompt.
- If you arrive after your scheduled appointment time, your appointment may need to be rescheduled.

Cancelling Your Appointment

24 hours advanced notice is required for cancellation of any appointment.

- Please call us as soon as you know you won't be able to make your appointment. Calling the day before will help us to make that appointment available to someone who may need urgent or sick care.
- If you are a new or established patient and you do not show up for 2 consecutive appointments, and you do not call to cancel, we will consider that a termination from the practice.
- A "no-show" to your appointment will result in a $25.00 charge that must be paid prior to any future appointments.

When You Need Us After Hours

- When you call our office after hours, you will be directed to our answering service. The representative will take your call and forward your message to the on-call provider.
- If you are experiencing a medical emergency or you believe you are experiencing a life threatening situation, call 911 immediately, or go to the emergency department of your nearest hospital.
- If your urgent medical need is not life threatening, and it is during normal business hours, please call the office. We will help you determine the best plan of care.

Your Results for Diagnostic Testing

We know that you want to know the results of your lab tests and other diagnostic testing as soon as you can.

- When test results are returned to the office, they are first reviewed by your doctor or provider. As soon as they are available, our nursing staff will notify you of your results either by phone or by letter. Please do not call to request test results before two weeks have passed.
- You may be asked to call the office and make a follow-up appointment with your doctor to discuss the test results and follow-up plan, if necessary.

Refilling Your Prescription

- When you need a general prescription filled, contact your pharmacy. The pharmacy will notify your provider through a secure electronic prescription refill system called E-Rx. Check with your pharmacy to see if they participate in the E-Rx system. If they don't, your provider will provide you with hard copies of your prescription to bring to your pharmacy.
- Please allow at least 48 hours for all prescription refill requests.
- If you need a refill for a controlled medication, an appointment may be required.

Referrals for Specialty Care

- When it comes to referrals, there are many things to consider- your doctor's special orders, whether the specialist participates with your insurance company, and getting an appointment scheduled as soon as possible. Please allow time for the staff to get the appropriate referral done.

- Please communicate with your provider regarding any specialists you are seeing. This will ensure that the appropriate referrals are done, and will keep your primary care doctor in the loop.

When You Need a Form Filled Out

We are happy to help you when we have advance notice.

- We are happy to accept medically related forms that require your doctor's signature.
- First, fill out all of the information about the patient, like your name, address, date of birth, social security number, and employer. Make sure to sign your name if the form requires it. Then give the form to the receptionists at the front desk. They will forward your form to the forms nurse, who will then route it to your provider.
- We cannot complete forms for pick up on the same day. We will call you when the form is ready, within 7 to 10 business days.
- A fee of $40.00 will be charged.

Sending Your Records to Another Doctor

You may request a copy of your medical record.

- Sometimes, our patients will need a copy of their medical record in order to transfer to another doctor. A records release form must be filled out in order for our records department to transfer your records to another doctor.
- Our patients may request a copy of their medical record for themselves, an insurance application or legal representation. The patient, insurer, or legal counsel will be billed at $25.00.

Paying Your Bill

- Payment for your visit is due at the time of service. You may have a co-pay, co-insurance, or deductible that will be due at the time of your visit.
- Our knowledgeable and experienced billing department is ready to help you with payment and insurance related questions. They are available Monday through Friday, 8:00am until 4:30pm.
- If your account has been turned over for collection, balance in full will be expected prior to next visit.

Patient Termination Policy

- Although it is an infrequent occurrence, a patient/physician relationship may be terminated. Common reasons for termination include, but are not limited to, use of foul language, chronic noncompliance with recommended therapy, abusive behavior to staff, physicians, visitors or other patients, or other disruptive behavior. Recommendation of termination by any Pampa Medical Group provider could exclude the patient from seeing any other provider in the group.