FAX

To: Texas Tech Physicians

Fax #: 432-335-5303

Date:

From: Marathon Health Center

Fax #:

Pages: 7 including cover page

Notes

Texas Tech Physicians
of the PERMIAN BASIN

Date: _____ D#: _____

SECTION 1	PATIENT INFORMATION				
Patient Full Legal Name		Date of Birth	SSN	Sex ☐ Male ☐ Female	
Address (Number) (Street) (Apt. No.)					
City	State	Zip	Phone (Home)	Phone (Cell)	
Marital Status		Employer			
Emergency Contact Name		Relationship	Contact Phone		
Spouse		Contact Phone			

The Following Responsible Party is the "Guarantor" and is responsible for the cost of services to the Patient:					
Full Legal Name	Date of Birth	Relationship to Patient			
Address (if different than Patient)	City	State	Zip	Phone (Home)	Phone (Cell)

The following Information is regarding the Insurance cardholder if other than Patient or Responsible Party:		
Full Legal Name	Date of Birth	Social Security Number

SECTION 2:	Primary and Secondary Insurance if applicable	
Primary Insurance Name		Subscriber Name
DOB	Relationship	Policy Number
Group Number	Claims Address	
Secondary Insurance Name		Subscriber Name
DOB	Relationship	Policy Number
Group Number	Claims Address	

Texas Tech University Health Sciences Center

Confidential Communication Request

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date

Print Your Name and Relationship to Patient (Person signing consent form)

Signature (Patient or Other Legally Authorized Person)

Relationship to Patient

Texas Tech University Health Sciences Center Ambulatory Clinics Consent to Treatment/Health Care Agreement	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

ADVANCE DIRECTIVE:

Do you have a current, signed Advance Directive? ____YES ____NO
Has a signed copy been provided to TTUHSC? ____YES ____NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date **Print Name** **Signature Patient/ legally authorized person**

Witness/Translator **Relationship to Patient**

Revised January 2020
6.21.B

Texas Tech University Health Sciences Center **Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications**	Patient Name: _____ MRN: _____ DOB: _____

☐ I have received a copy of the Texas Tech University Health Sciences Center (TTUHSC) Notice of Privacy Practices (rev. 3/16) in accordance with 45 CFR § 164.520.

Consent to Email or Text Usage for Appointment Reminders and other Healthcare Communications:

☐ I consent to receive email and/or text messaging from TTUHSC to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general health reminders or information about new services.

The cell phone number and/or email I authorize for TTUHSC to use are listed below:

Email: _____

Cell phone number: _____

TTUHSC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

By signing below, I acknowledge any options selected above, will remain in effect until further written notification by me.

Date	Print Your Name (Person signing consent form)	Signature (Patient or Other Legally Authorized Person)
		Relationship to Patient

Health Information Exchange (HIE) Participation Change

UMC HEALTH SYSTEM

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Name: _____ Date of Birth: _____

Street Address: _____ Medical Record #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

University Medical Center, Texas Tech University Health Sciences Center and UMC Physicians participate in a Health Information Exchange (HIE). The HIE is a secure, electronic way of sharing health information among participating hospitals, doctors' offices, pharmacies, and other healthcare providers. An HIE is important because sharing health information improves care. The HIE helps participating providers share information in a timely manner and more effectively coordinate your care.

I wish to change my participation status in the HIE. I have selected the correct status below:

O I DO NOT WANT TO PARTICIPATE IN THE HIE

After considering my option of participating in the HIE, I have decided to OPT OUT and NOT participate in the HIE. By choosing to OPT OUT of the HIE, I hereby acknowledge and agree as follows:

1. Opting out of the HIE may delay access to important medical information.
2. My health information will not be shared among healthcare providers through the HIE. Instead, my providers will continue to share my information via previously established methods, such as phone, fax, or mail.
3. My health information will NOT be shared with other HIEs in which UMC, TTUHSC, and UMCP may participate.
4. Any information that is shared before I submit this HIE Opt-Out form may remain with providers who accessed information before this Opt-Out went into effect.

O I WANT TO PARTICIPATE IN THE HIE

I previously opted out of participating in the HIE, but I have changed my mind. I want my medical information to be shared with healthcare providers through the HIE.

I understand that my HIE selection above will remain in effect unless I change it in writing. I understand that this request can take up to 3-5 business days to take effect.

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting on behalf of the person named above as: (Check One)

❑ Parent ❑ Legal Guardian ❑ Other (Specify Relationship): _____

Printed Name: _____ Date: _____

Signature: _____

Please forward the completed and signed HIE Opt-Out Forms to UMC by one of the following methods:

1. Fax to: 806-775-9157
2. Mail to: University Medical Center-Health Information Management; 602 Indiana Avenue; Lubbock, TX 79415

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: March 3, 2016

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

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

- **Get an electronic or paper copy of your medical record**. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

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

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