

# Cy-Fair Medical Partners

## PATIENT INFORMATION FORM

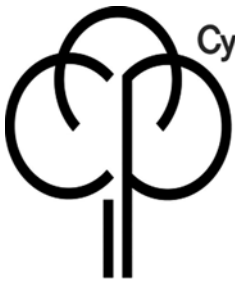
PHYSICIAN'S NAME \_\_\_\_\_

PATIENT'S FULL NAME		MAIDEN NAME	
ADDRESS		APT. #	PHONE NUMBER ( )
CITY	STATE	ZIP	WORK NUMBER ( ) CELL NUMBER ( )
SEX <input type="checkbox"/> F <input type="checkbox"/> M	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER _____	DATE OF BIRTH MM/DD/YY	PATIENT'S SOCIAL SECURITY #
PATIENT'S EMPLOYER			
EMPLOYER'S ADDRESS			
SPOUSE'S/GUARDIAN'S NAME	WORK NUMBER ( ) CELL NUMBER ( )	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY #
EMPLOYER		ADDRESS	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE # ( )
<b>PRIMARY INSURANCE COVERAGE</b>			
INSURANCE COMPANY		INSURED'S DOB	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____
NAME OF INSURED			COPAY AMOUNT
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS			INSURANCE PHONE #
CITY		STATE	ZIP
POLICY NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY #	
<b>SECONDARY INSURANCE COVERAGE</b>			
INSURANCE COMPANY		INSURED'S DOB	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____
NAME OF INSURED			COPAY AMOUNT
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS			INSURANCE PHONE #
CITY		STATE	ZIP
POLICY NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY #	
ANY OTHER INSURANCE COVERAGE	<input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY NAME	PHONE # ( )
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		PRIMARY CARE PHYSICIAN	

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Cy-Fair Medical Partners/IMPEL to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Cy-Fair Medical Partners/IMPEL. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ form. A-04.New.Patient.12321 Rev. (04/08)



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If minor, Accompanying Adult's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns you would like to discuss with your doctor today:

\_\_\_\_\_

\_\_\_\_\_

Please list your **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea)

Please provide your **IMMUNIZATION HISTORY**:

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster				Hepatitis A Vaccine			
Influenza Vaccine (Flu Shot)				Hepatitis B Vaccine			
Pneumococcal Vaccine				Human Papilloma Virus (HPV)			
Tuberculosis (TB) Skin Test				Varicella Vaccine			

Please provide your **PAST MEDICAL HISTORY**:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Bronchiolitis            | <input type="checkbox"/> Fracture           | <input type="checkbox"/> Prematurity            |
| <input type="checkbox"/> Abdominal Pain    | <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> GERD (reflux)      | <input type="checkbox"/> Pyleonephritis         |
| <input type="checkbox"/> Acne              | <input type="checkbox"/> Chickenpox               | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Recurrent otitis media |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Concussion, CHI          | <input type="checkbox"/> Hearing problems   | <input type="checkbox"/> Seizure disorder       |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Seizures – febrile     |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> UTI                    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Vesicoureteral reflux  |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Pneumonia          |   |

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if known**:

- |   |   |
|---|---|
| <input type="checkbox"/> Appendectomy                     | <input type="checkbox"/> Adenoidectomy              |
| <input type="checkbox"/> Inguinal Hernia Repair           | <input type="checkbox"/> PET placement              |
| <input type="checkbox"/> Fracture with Surgical Reduction | <input type="checkbox"/> Lymph node biopsy/excision |
| <input type="checkbox"/> Dental Surgery                   | <input type="checkbox"/> Umbilical Hernia Repair    |
| <input type="checkbox"/> Tonsillectomy                    |   |

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY**:

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Allergies					
Asthma					
Birth defects					
Cancer, Type _____					
Coronary artery disease (heart disease)					
DDH (hip dysplasia)					
Deafness					
Depression					
Developmental delay					
Diabetes					
Eczema					
Diabetes					
Genetic disorder					

	Mother	Father	Sister	Brother	Other
Hemoglobinopathy					
High cholesterol					
High blood pressure					
Learning disability					
Mental retardation					
Migraines					
Obesity					
Scoliosis					
Seizure disorder					
SIDS					
Strabismus (crossed eyes)					
Thyroid disease					
Other:					

Please provide age-appropriate **SOCIAL HISTORY**:

**Primary Residence:**  
Who lives with your child? \_\_\_\_\_  
\_\_\_\_\_

**Child Care:**  
Who provides care for your child? # days/wk:  
\_\_\_\_ Mother \_\_\_\_\_ days/wk  
\_\_\_\_ Father \_\_\_\_\_ days/wk  
\_\_\_\_ Grandparent \_\_\_\_\_ days/wk  
\_\_\_\_ Other \_\_\_\_\_ days/wk  
\_\_\_\_ Day Care \_\_\_\_\_ days/wk

**Sleep:**  
Does child get 8.5 hrs of sleep? Yes No  
Does child have sleeping problems? Yes No

**Tobacco Exposure:**  
Are there smokers at home? Yes No  
If yes, do they smoke outside only? Yes No

**Relationships:**  
Cooperates with family/friends Yes No  
Cooperates with teachers Yes No  
Are there concerns about relationships Yes No

**Home Environment:**  
What is the age of the home: \_\_\_\_\_  
Is water Chlorinated? Yes No  
Is water Fluoridated? Yes No  
Is there lead in the home? Yes No

**Activity:**  
Exercise/Sports: \_\_\_\_\_ hrs/day  
TV/Computer Games: \_\_\_\_\_ hrs/day

**Safety:**  
Does child use bike/skate helmet? Yes No  
Does child use seat belt in the car? Yes No  
Is there a carbon monoxide detector? Yes No  
Are smoke detectors in the home? Yes No  
Are there firearms in the home? Yes No  
Are there pets in the home? Yes No  
If yes, what kind? \_\_\_\_\_

**Education:**  
School Name: \_\_\_\_\_  
School Grade: \_\_\_\_\_  
Does child have any learning disabilities? Yes No  
Does child have any special needs? Yes No

Please provide additional **SOCIAL HISTORY** as appropriate:

Do you Smoke? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Former  
Type of tobacco: \_\_\_\_\_  
Packs per day: \_\_\_\_\_  
Do you use Drugs? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Former  
Type: \_\_\_\_\_  
Frequency: \_\_\_\_\_

Do you drink Alcohol? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Former  
Age started: \_\_\_\_\_  
Type of alcohol: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Amount: \_\_\_\_\_

**FOR FEMALES ONLY:**

Age at First Period: _____	Are periods regular? ____Yes ____No	Number of Pregnancies: _____
Date of Last Menstrual Period: _____		Number of Live Children: _____
Date of Last Mammogram: _____	Do you have pain with period? ____Yes ____No	Number of Miscarriages: _____
Date of Last Pap Smear: _____		Number of Abortions: _____
Any history of abnormal pap smears? ____Yes ____No	Is Flow ____Normal ____Heavy ____Light ____Spotting	
If Yes, When: _____		

**Cy-Fair Medical Partners**

**CONSENT TO MEDICAL TREATMENT OF A MINOR**

Date: \_\_\_\_\_

To Whom it May Concern:

I hereby give my permission for Dr. \_\_\_\_\_, to  
examine and to treat my child \_\_\_\_\_.  
Name of Patient

\_\_\_\_\_ is \_\_\_\_\_ years of age.  
Patient

\_\_\_\_\_  
Parent or Guardian

## **Cy-Fair Medical Partners Consent for Treatment**

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Cy-Fair Medical Partners unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to Cy-Fair Medical Partners' infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Cy-Fair Medical Partners. If any of these situations occur during your treatment period.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

PATIENT INFORMATION (Please Print):

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_

RELEASE OF MEDICAL RECORDS FROM:

NAME: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FAX NO: \_\_\_\_\_

SEND TO:

**Cy-Fair Medical Partners**

Attn: \_\_\_\_\_

**12101 Grant Rd., Ste. G**

**Cypress, TX 77429**

Please send a copy of the following medical records only:

- Lab Reports and Lab Results**
- Diagnostic Reports**
- Consultation Reports**
- Immunization Records**
- Last Clinic Visit Note**

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: \_\_\_\_\_ Date \_\_\_\_\_

**CY-FAIR MEDICAL PARTNERS  
FINANCIAL POLICY**

Thank you for choosing Cy-Fair Medical Partners as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

❖ **It is your responsibility to provide us with your most current insurance information.**

- ✎ If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- ✎ We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- ✎ If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- ✎ We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- ✎ Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- ✎ We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- ✎ Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

✎ **It is your responsibility to provide us with your most current billing information.**

- ✎ You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- ✎ We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call **(817)514-5200** or **1-800-555-1429**.
- ✎ **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a \$5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- ✎ If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- ✎ If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Cy-Fair Medical Partners. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- ✎ In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- ✎ We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- ✎ **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Signature of Responsible Party

Date

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_



Patient Name: _____
Medical Record Number: _____

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_, have received the Notice of Privacy Practices from  
(patient name)

Cy-Fair Medical Partners (CFMP).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a patient representative/ staff  
(patient representative)

member of CFMP, state that \_\_\_\_\_ has been given our current  
(patient name)

Notice of Privacy Practices.

Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Cy-Fair Medical Partners to share my protected health information with:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

If patient refuses to sign, please state the reason(s) below:

# Cy-Fair Medical Partners

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER STEPHEN EPPSTEIN, M.D. AT (817) 514-5200.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services.

We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, [www.MCNT.com](http://www.MCNT.com), or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. An updated copy will also be posted in your physician's office.

### 1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a radiologist or pathologist) who, at the request of

your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare (Clinic) Operations:** We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and nursing students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical and nursing school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services, telephone answering services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may send you information about products or services that we believe may be beneficial to you.

### Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health

care will be disclosed. We may use and disclose your protected health information in the following instances:

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation.

### Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** If you choose to participate in medical or scientific research, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about your health care. The request must be made in writing to **Cy-Fair Medical Partners**. If you request a copy of your medical record, your physician's office will provide you a copy within 30 days.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting your written request to the manager of your physician's clinic.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative

address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer at 9003 Airport Freeway, Suite 300, North Richland Hills, Texas 76180.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information for the purpose of correcting an error or misinformation. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and that statement will become part of your medical record. Your physician may prepare a rebuttal to your statement which will also become part of your medical record. Your physician will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes *other* than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

## **3. Questions or Complaints**

If you have a question or complaint about your privacy rights, please file a grievance form with the site manager of the clinic where you encountered a problem, or contact the Privacy Officer for **Cy-Fair Medical Partners** at **(817) 514-5200**. Should the Privacy Officer be unable to resolve your complaint to your satisfaction, you may contact the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

**This notice became effective on April 14, 2003.**

**Revisions/Addenda to Notice of Privacy Practices**

### **Family/Joint Accounts**

If you or a family member receives bills with more than one person listed on the bill, you may have a joint or family account through MCNT. As a patient with this type of account, you have two options: (1) continue with a joint account or (2) request separate accounts for all members of your family. If you wish to continue to receive your bills as a joint/family account, you need take no action. If you choose to separate your joint accounts, requests must be made in writing and submitted to:

### **Cy-Fair Medical Partners**

Central Business Office Customer Service/  
Collections Personnel  
9003 Airport Freeway, Suite 300  
North Richland Hills, Texas 76180  
**(817) 514-5200 phone**  
**(817) 514-5210 fax**



# PLEASE CALL YOUR INSURANCE COMPANY TODAY.

As you are probably aware, coverage under most health insurance policies HAS CHANGED. In an effort to assist our patients in understanding their insurance coverages, we have defined the following as **questions that you should ask** your insurance company. Whether you have a new insurance company (or you have had the same insurance plan for years), these questions should be asked TODAY to determine any changes in coverage. These are only a few suggestions, so please ask any other questions you may have when you make the call.

1. What is my effective date? \_\_\_\_\_

2. If I have coverage with more than one insurance, which insurance is primary?

Which is secondary?

Which company is the primary for my child if both myself and spouse have coverage?  
\_\_\_\_\_

3. Is my insurance an HMO, POS, PPO or indemnity? What does this mean?

4. Do I have out of network benefits? \_\_\_\_\_

5. Does my insurance require written referrals to specialists? \_\_\_\_\_

6. Do I have a deductible? \_\_\_\_\_ What does that mean to me, and how much has been met?

What is the deductible for?  
\_\_\_\_\_

7. Will I have co-insurance amounts due over and above my copay? \_\_\_\_\_  
If yes, what are those amounts? \_\_\_\_\_  
\_\_\_\_\_

8. What is my doctor (PCP) office visit copay? \_\_\_\_\_  
Specialist office visit copay? \_\_\_\_\_ Is my OBGYN treated as a specialist if I only go for my annual gynecological visit? \_\_\_\_\_

9. How often can I and/or family members have a preventive physical/well woman exam/well child visit? \_\_\_\_\_ According to your records, when did I and/or my family members last have these types of exams? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there a copay for a preventive physical/well woman exam/well child visit? \_\_\_\_\_ How much? \_\_\_\_\_

When I and/or family members have a preventive physical/well woman exam/well child visit, is there anything that is NOT covered?  
\_\_\_\_\_

How much do I have to pay? \_\_\_\_\_

10. Is there a cost limit, coinsurance or deductible on my preventive coverage? \_\_\_\_\_ If so, how much? \_\_\_\_\_

11. Is there a **copay, coinsurance or deductible** if I have labs or procedures done without seeing the physician or physician assistant? \_\_\_\_\_  
What if the procedures or lab work occur on a day(s) before or after my appointment? \_\_\_\_\_

12. Do I have coverage for screening tests? (Colonoscopy, stress test, labs, mammograms, bone density testing, EKG, etc.) If so, what is the rate at which these tests are covered?

13. Do I have coverage for preventive immunizations? \_\_\_\_\_ Travel Immunizations? \_\_\_\_\_  
Is there a co-pay when I go to the doctor for immunizations only? \_\_\_\_\_ For children, is there an annual cost limit for preventive immunizations? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

14. What pre-existing conditions are NOT covered by my insurance?

**NOTE:** Medicare patients should find out when co-payments apply, especially when Medicare is offering a particular health service/exam.