# NOTICE OF PRIVACY PRACTICES

## EFFECTIVE DATE: 2/25/08

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

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways generally described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and disclosures in each category.

We may use and disclose your health information for treatment, payment, and health care operations.

Treatment: We may use and disclose your information to provide you with medical treatment and services. Your information may be disclosed to individuals providing care to you and different departments in this facility. These individuals and departments need your information to provide care, and to coordinate and provide services (such as prescriptions, lab tests, and x-rays). We may also disclose your information to individuals or entities other than this facility that may be involved in your care such as your primary physician, consulting technicians or physicians, or emergency department physicians.

Payment: We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or third party paying for your care or treatment. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine where her your health plan will cover the treatment. We may disclose your information to another healthcare provider so it can receive payment for services provided to you. We may also disclose your information to a collection agency or to a consumer credit reporting agency.

Health Care Operations: We may use and disclose your information for health care operation purposes. Health care operations include review of the care you receive for quality assessment, educational, business planning, and compliance plan purposes.

We may disclose and use your health information for:

Appointment Reminders: We may provide appointment reminders to you. You may request in writing that we send to a confidential or alternative address.

Treatment Alternatives: We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities without your authorization in the following circumstances:

Required by Law: We disclose information as required by law. For example, we are required to report gunshot wounds to the police.

Public Health Purposes: We disclose information the health agencies as required by law. Examples are reporting of sexually transmitted, communicable, and infectious diseases.

Employer: We disclose information to your employer about work-related illness or injury as required by law.

To Prevent a Serious Threat to Health of Safety: We may disclose information about you to law enforcement or an

identified victim to prevent a serious threat to your health or safety or the health or safety of another individual or the public.

Research: Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.

Health Oversight Activities: Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.

Judicial and Administrative Proceedings: We may be required to disclose your health information to a court or for an administrative proceeding.

Law Enforcement Activities: We may be required to disclose your information as required by law, pursuant to a court order, warrant, subpoena, or summons, or if you are the victim of a crime.

In Emergency Circumstances

Deceased Individual: We may disclose information for the identification of the body, to determine the cause of death or to alert law enforcement of your death.

Military and Veterans: If you are a member of the armed forces, we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Protective Services for the President and Others

Organ and Tissue Donation: If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ and tissue donation.

Workers Compensation: We may release medical information about you for workers compensation or similar programs.

National Security and Intelligence Activities: We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We will give you the opportunity to object to the following uses and disclosures of your information:

Notification: We may tell your friends, relatives, and other caretakers information about your location, your general condition, or notification of death.

Communication with Family: We may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that persons involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief; We may disclose information about you to public or private agencies for disaster relief purposes.

## Your Rights

You have the right to request a restriction on how information about you is used and disclosed. We are not required to agree to any restriction on the use or disclosure of your information.

You have the right to request communications with you be made at an alternative address or phone number.

You have the right to inspect and copy your medical records.

If you believe the information we have about you is incorrect or incomplete you may request that we amend your medical record.

You have the right to receive an accounting of disclosures, a list of individuals and entities that received your health information for reasons other than treatment, payment, healthcare operations. In general, you do not have a right to an accounting if we are authorized by law to release your information without your prior authorization or if you authorize release of your information.

You have the right to request a paper copy of this Notice.

To make any of the above requests, contact the Office Manager of Amarillo Urgent Care at 806-352-5400.

## Our Duties

We are required by law to maintain the privacy of protected health information and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.

We are required to follow the terms of the current Notice.

Uses and disclosures of your health information not permitted by law will require your written authorization. You may revoke any such authorization unless we have already acted in reliance on your authorization.

We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted at Amarillo Urgent Care and a copy may be requested from the Office Manager.

## Information or Complaints

If you have questions about this notice, want more information, or if you believe your privacy rights have been violated you may contact: the Office Manager of Amarillo Urgent Care at 806-352-5400, the Secretary of The Department of Health and Human Services, or the Texas Department of Health and the Environment. You will not be penalized for filing a complaint.

# TREATMENT CONSENT

Amarillo Urgent Care is an urgent care center. Medical services rendered at this clinic are considered urgent care. Urgent Care is defined as medical, surgical, and related healthcare services for the evaluation and treatment of an injury or illness which a lay person feels requires prompt evaluation and treatment by a healthcare professional. I understand that by signing in for evaluation at Amarillo Urgent Care, I am seeking urgent care services. I understand that urgent care may incur additional costs over and above those at my regular physicians office. My health insurance plan may assess additional charges over what I would pay at my regular physicians office. I understand that it is my responsibility to understand these benefits.

## MEDICAL AND SURGICAL CONSENT:

The signer or his or her dependent is suffering from a condition requiring diagnosis and medical treatment. The signer, does hereby voluntarily agree to diagnostic procedures and services and medical and or surgical treatment which may be administered to or performed on the patient or his or her dependent under the instruction of the attending physician by the physician, his or her assistants or his or her designees.

The signer understands that x-rays ordered by the evaluation practitioner that are performed by another designated radiology facility and will be billed separately. Laboratory work ordered by the evaluating physician may be forwarded to outlying laboratories for analysis and will be billed separately.

## RELEASE OF INFORMATION:

The signer authorizes the physicians at Amarillo Urgent Care to disclose all or any part of the patients record to any person or corporation which is or may be liable under a contract to the physicians of Amarillo Urgent Care or to the patient or the employer of the patient for all or part of the physicians charges for its services including but not limited to workers compensations carriers, insurance companies, welfare funds, or the patients employer. I understand that following the release of these records neither Amarillo Urgent Care or its physicians will be responsible for the confidentiality of any documents released in accordance with this consent.

The signer authorizes the treating physician at Amarillo Urgent Care to obtain any medical records from prior hospital visits or previous physician evaluations that may be pertinent and important in the diagnosis and treatment of the condition the signer and/or his or her dependent is seeking medical evaluation for today.

## PAYMENT AGREEMENT:

Payment for services is expected at time and date that services are rendered. If we file a claim with your insurance carrier, you will be responsible for any co-payment, deductible, and for any services not covered by your insurance company. It is the responsibility of the patient or his/ her guardian to verify covered benefits (i.e. urgent care benefits) with your insurance carrier. If we file a claim for work related or auto accident related injuries and the claim in denied, you will be responsible to pay the bill in full. A $20 fee will be assessed for any returned checks. Unpaid balances may be sent to an independent collection agency if not paid in a timely manner. Interest may be included for any outstanding fees.

**I have read the Acknowledgements and Agreements, and fully understand the same.I attest that the above information is true and correct to the best of my knowledge. I understand this treatment consent applies to this visit and all future visits.**

Amarillo Urgent Care
1915 S Coulter
Amarillo, TX 79106
Phone: 806-352-5400

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|---|---|---|
| Name | DOB: | Sex: |
| Acct #: | MR | |
| Visit Date: | | |

# PATIENT SIGNATURE FORM ACKNOWLEDGEMENT

I acknowledge that I have offered a copy of the Financial Agreement, Notice of Privacy Practices and Treatment Consent. I have read them, been given the opportunity to ask questions, and my questions have been answered satisfactorily. I acknowledge that I am signing these forms through an electronic signature pad and that the electronic image will become the original document and that copies of this image may be used in place of the original.

Patient or Representative Signature