FAMILY MEDICAL CENTER

Dean Zincone, MD (Physician) & **Dan Thull, PA-C** (Physician's Assistant)

Patient Information

Name:____ **Date:**____________
Last First MI

Address:____

City:______________________________ **State:**_____________ **Zip:**____________

Birth Date:_________________________ **SSN:**_____________________________

Phone #'s: Home:_______________________ Cell :___________________________

Preferred contact (circle) Home Cell or email:_____________________________________

Employer:_____________________________________ **Phone:**_____________
Address:____
City:____________________ **State:**__________ **Zip:**_______________

Marital Status:(please circle one) **S M D W** **Sex: F M** **Age:**________

Responsible Party Information

If other than patient

Name:______________________________________ **Relation to patient:**________

Address:____

City:___________________________ **State:**_____________ **Zip:**______________

Birth Date:________________________ **SSN:**_____________________________

Phone #'s: Home:________________________ Cell:__________________________

Employer:_____________________________________ **Phone:**_____________
Address:____
City:____________________ **State:**______________ **Zip:**________________

Insured Person's Information

Please give insurance cards to receptionist for copying.

Insured Name:____________________________________ **Birth Date:**__________
Last First MI

Address:____

City:______________________________ **State:**_____________ **Zip:**______________

SSN:______________________________ **Phone #:**___________________________

Employer:______________________________**Phone:**__________
Address:____
City:______________**State:**__________**Zip:**__________
Relationship to patient:______________________________

Do you have Secondary Ins? _____**Y**__________**N**_______

Secondary Ins: Please give card to recptionist ______________________________

Insureds Name:______________________**Birth Date:**__________
Employer:__________________________**Phone:**__________
Address:____
City:______________**State:**__________**Zip:**__________

Emergency Contacts

Name:______________________**Phone #:**________________

Name:______________________**Phone #:**________________

Payment Method **Cash**______**Check**_______**Credit Card**________

Payment Policy and Authorization of payment:

All Services rendered are the financial responsibility of the patient or the patient's parent or guardian at the time of services rendered. The patient is responsible for payment regardless of insurance coverage. Billing information should be provided to expedite payment from insurance carriers. **Delinquent accounts are subject to interest plus all fees for collections if account is referred to an outside agency.**

Lifetime Authorization of payment
I hereby authorize the Dr. Zincone's to release information concerning my examination and/ or treatment for insurance purposes and I also authorize direct payment to Dean Zincone, M.D. for benefits payable from my insurance company.

Signed:____

Preferred Language:______________________________

Please circle each appropriately below

Race: American Indian or Alaska Native
Black or African American
Native Hawaiian or other Pacific Island
White
Other Race

Ethnic Group: Hispanic or Latino
Not Hispanic or Latino

Other physicians seen:

Name:______________________________ **for what:**______________________________

Name:______________________________ **for what:**______________________________

Name:______________________________ **for what:**______________________________

Name:______________________________ **for what:**______________________________

Name:______________________________ **for what:**______________________________

Please list any additional physicians seen in space below.

NO SHOW POLICY:

There is a $25.00 for no-show appointments. Please call to reschedule your appointment to avoid the charge.
This is your responsibility and not payable by your insurance, Medicare or Medicaid.

____

Please acknowledge policy Date

Dean L. Zincone, M.D.
1355 E. Court St
Seguin, TX 78155
(830) 401-4401
Metro (830) 303-5224
Fax (830) 303-5225

Physician Assistant Consent for Treatment

This facility has on staff a physician assistant (Daniel R Thull) to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

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

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

Name:	Date:
Signature:	Witness: (optional)

HIPAA PATIENT ACKNOWLEDGEMENT FORM
for patient to sign.

HIPAA PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: ___________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for _____________________________________. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

____ ____

Please ***print*** your name Please ***sign*** your name

____ ____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW HEALTHCARE INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___ It was emergency treatment
___ The patient refused to sign
___ Other (please describe)
___ I could not communicate with the patient
___ The patient was unable to sign because
____

____

Signature of Privacy Officer

The Practice Privacy Notice

Effective Date: April 14,2003

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.

If you have any questions about this notice, please contact The *Practice's* Privacy Officer.

WHO WILL FOLLOW THIS NOTICE.

This notice describes the policies of *The Practice* and that of all employees, staff and other personnel of *The Practice*.

This notice also describes the standards we will ask Business Associates of *The Practice* to adhere to should they have access to you/your child's medical information during routine work for *The Practice*. For example, if a computer technician will be allowed to service a computer in *The Practice*, that technician or that technician's company will be asked to sign an agreement that respects the privacy of your family's medical information.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you/your child is personal. We are committed to protecting medical information about you/your child. We create a record of the care and service you/your child receives at *The Practice*. We need this record to provide you/your child with quality care and to comply with certain legal requirements. This notice applies to all of the records of you/your child's care generated at *The Practice*.

This notice will tell you about the ways in which we may use and disclose medical information about you/your child. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you/your child is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you/your child; and
- follow the terms of the notice that is currently in effect.

DEFINITION:

Medical information about you/your child includes: medical history, physical findings, test results, diagnoses, and treatments. It also includes medical information about your family that has relevance to you/your child's healthcare. For example, if another child has an illness this may be relevant to a treatment plan developed for you/your child. It also includes social information about your family that may be relevant to you/your child's healthcare. For example, if a family has just moved to a new home, or if a parent has had a change in employment, this may be relevant to you/your child's evaluation and treatment.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU/YOUR CHILD.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. **For Treatment**. We may use medical information about you/your child to provide you/your child with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel of *The Practice* who are involved in taking care of you/your child at *The Practice*. Different areas/locations of *The Practice* also may share medical information about you/your child in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you/your child to professionals outside of *The Practice* who may be involved in you/your child's medical care. For example, a doctor involved in treating a child's broken bone needs to know if that child has Diabetes or other medical conditions that might complicate the healing process. Finally, we may disclose information to others, such as family members, clergy, etc, if 1) we are confident this would be acceptable to you, and 2) these individuals are clearly active in you/your child's care and/or support.

2. **For Payment**. We may use and disclose medical information about you/your child so that the treatment and services you receive at *The Practice* may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure you/your child received at *The Practice* so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you/your child is going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3. **For Health Care Operations**. We may use and disclose medical information about you/your child for operations of *The Practice*. These uses and disclosures are necessary to run *The Practice* and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you/your child. We may also combine medical information about many patients in *The Practice* to decide what additional services we should offer, what services are not needed, and how effective selective treatments have been. We may also disclose information to medical students and other trainees for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you/your child from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. If we are unable to remove identifying information we will take steps to ensure that the information is used only as intended.

4. **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you/your child has an appointment for treatment or medical care at *The Practice*.

5. **Treatment Alternatives**. We may use and disclose medical information to tell you about possible treatment options or alternatives that may be of interest to you.

6. **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

7. **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you/your child to a friend or family member who is clearly involved in you/your child's medical care. We may also give information to someone who helps pay for you/your child's care.

8. **Research**. Under certain circumstances, we may use and disclose medical information about you/your child for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received a medication to those who were treated prior to the availability of that medication. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people *preparing* to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave *The Practice*. We will always require that a researcher sign a pledge (a legal commitment) to honor the confidential nature of you/your child's medical information.

9. **As Required By Law**. We will disclose medical information about you/your child when required to do so by federal, state or local law.

10. **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you/your child when necessary to prevent a serious threat to you/your child's health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

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

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

13. **Public Health Risks**. We may disclose medical information about you/your child for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

14. **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight

activities include, for example, 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.

15. Lawsuits and Disputes. If you or you/your child is involved in a lawsuit or a dispute, we may disclose medical information about you/your child in response to a court or administrative order. We may also disclose medical information about you/your child 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 tell you about the request or to obtain an order protecting the information requested.

16. Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at *The Practice*; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

17. Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

18. National Security and Intelligence Activities. We may release medical information about ~~you/~~you/your child to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

19. Protective Services for the President and Others. We may disclose medical information about you/your child to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

20. Inmates. If you/your child is an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you/your child to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you/your child with health care; (2) to protect you/your child's health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU/YOUR CHILD.

You have the following rights regarding medical information we maintain about you/your child:

21. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about you/your child's care. Usually, this includes medical and billing records, but does not include psychotherapy notes or notes made as a result of a confidential visit by an adolescent if 1) you have approved this confidential visit, or 2) the law otherwise protects the confidentiality of this visit.

To inspect and copy medical information that may be used to make decisions about you/your child, you must submit your request in writing to BarbaraBeicker. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by *The Practice* will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

22. Right to Amend. If you feel that medical information we have about you/your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for *The Practice*.

To request an amendment, your request must be made in writing and submitted to BarbaraBeicker. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for *The Practice*;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is without question accurate and complete.

23. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you/your child. Exception: disclosures to individuals made as part of activities 1- 7 above are not tracked (every therapist, every nurse, etc. involved with your care, etc) and, therefore, will not be included in the accounting of disclosures provided to you. To request this list or accounting of disclosures, you must submit your request in writing to BarbaraBeicker. Your request must state a time period which may not be longer than six years and may not include dates before April 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

24. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you/your child for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you/your child to someone who is involved in your care or the payment for you/your child's care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you/your child had to a specific family member.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you/your child emergency treatment.

To request restrictions, you must make your request in writing to Barbara Beicker. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to a grandparent.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Barbara Beicker. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

25. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

26. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will make available a copy of the current notice at each practice site. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you/your child registers for treatment or health care services we will offer you a copy of the current notice in effect. Clear and apparent signage may satisfy this stipulation.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with *The Practice* or with the Secretary of the Department of Health and Human Services. To file a complaint with *The Practice*, contact Barbara Beicker at (830) 401-4401. All complaints must be submitted in writing. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:
US Department of Health & Human Services:
200 Independence Ave. S.W.
Room 509 F, HHH Building:
Washington, DC 20201

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

If you provide us permission to use or disclose medical information about you for a specific purpose beyond that covered in this notice above, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.