Corridor Primary Care, P.A.
Internal Medicine
Financial Policies

Charges for medical services are due at the time services are rendered. Payment may be made with cash, check or credit card. Patients covered under PPO or HMO policies must pay copays/deductibles/coinsurances at the time of service. We will file your insurance claims as a courtesy to you. If your insurance carrier does not pay your account within 60 days of service, you will be responsible for payment. If Corridor Primary Care (CPC) doctors are not providers under your plan, payment is expected at the time of service and the claim will be filed as un-assigned. Payment arrangements can be made with the office manager if you are unable to pay your full balance due. Please ask to speak to the office manager at the time of your visit. Balances past due over 90 days will be collected by a collection agency.

Medicare patients
CPC accepts Medicare assignment. We will file all services performed in our office with the exception of lab work. Lab work is provided by independent labs. Supplemental policies will be filed if you provide our office with correct policy information. Supplemental claims returned due to incorrect information will be forwarded to the patient. Payment for services considered NON-COVERED by Medicare will be due at the time of such service.

PPO/HMO patients
CPC participates in many insurance plans. It is the patient's responsibility to verify that the CPC doctor is in your particular plan. To obtain a referral for specialist care, you must give us three (3) days notice prior to your specialist's appointment. The insurance plans will not allow us to "back date" referral authorizations. Payment for non-covered services is due at the time of such service. Please tell the staff if you have preventative or wellness benefits coverage.

Assignment of Benefits
I hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled, payable to Corridor Primary Care, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as an original. I understand I am financially responsible for all non-covered charges, deductibles, copays and coinsurance balances due. I have read the financial policies of CPC listed above. I authorize said assignee to release all information necessary to secure payment.

Name (please print)______________________________________
Date of Birth________________________

Signature **Date**

Notice of Privacy Practices

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the office manager

<u>Treatment, Payment, Health Care Operations</u>

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. [For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.] OR

[For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.]

<u>Disclosures That Can Be Made Without Your Authorization</u>

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:
- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person’s agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers’ Compensation
We may disclose your medical information as required by the Texas workers’ compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence

activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn’t created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

<u>Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits</u>

We may contact you by [telephone, mail, or both] to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Michelle Comstock
601B Leah Avenue
San Marcos, Texas 78666
512-392-1700

This notice is effective on the following date: April 14.2003

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

Corridor Primary Care, P.A.
Patient History Form

Name (Please print): ______________________ Age:________ Date of Birth: ____________

Form completed by: ______________________ Today's date: ______________

ALLERGIES (List substance and reaction)

Drugs ______________________

Food ______________________

Other (bees, latex, vaccines, etc.) ______________________

MEDICATIONS I TAKE (List prescriptions and over-the-counter products – use other side if necessary)

Name	Dose/How often	Name	Dose/How often

MEDICAL HISTORY

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke or Mini-stroke (TIA)
- ☐ Blood clot
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Heart failure
- ☐ Enlarged prostate
- ☐ Erectile dysfunction
- ☐ Frequent urinary infections
- ☐ Overactive bladder
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Abuse
- ☐ STI: Type?
- ☐ Diabetes with insulin
- ☐ Diabetes without insulin
- ☐ Thyroid: High? Low?
- ☐ Anemia
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Positive TB test
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Acid reflux/GERD
- ☐ Bleeding ulcer
- ☐ Hearing loss
- ☐ Depression
- ☐ Anxiety
- ☐ Hepatitis (type?)
- ☐ Osteoarthritis
- ☐ Rheumatoid/other arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Connective tissue disease
- ☐ Osteoporosis
- ☐ Peripheral nerve disease
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Seizures
- ☐ Memory loss/Dementia
- ☐ Migraines: with aura? Yes No
- ☐ Blood transfusion (when?) ____________
- ☐ Other: (treatment?)
- ☐ ADD/ADHD: When Diagnosed? __________________ By whom? ____________________
- ☐ Vitamin Deficiency: Types? ______________________
- ☐ Hormone Deficiency: Types? ______________________
- ☐ Cancer: Types? ______________________
- ☐ Serious Injuries: Types? ______________________

List any **SPECIALISTS** you see: ______________________

List any **SURGERIES** you have had: ______________________

FAMILY HISTORY (list who: Mother, Father, Maternal/Paternal Grandparents, Brother, Sister or Child)

High Blood Pressure ________________ Diabetes Type 1 ____________ Stroke ________________

High Cholesterol ________________ Diabetes Type 2 ____________ Alzheimer's ____________

Heart Disease________________ Osteoporosis ______________ Colon Cancer/Polyps____________

Breast Cancer ____________ Prostate Cancer ____________

Other Cancer (Type?) ______________________ Psychiatric Disorder ________________

Thyroid Disease __________ Other inherited problems ____________________________

SOCIAL HISTORY (Check all that apply)

- ☐ Single
- ☐ Married: How long? __________
- ☐ Divorced: When? __________
- ☐ Widowed: When: __________
- ☐ Partnered: How long? __________

Number of children: ______________

Faith preference: ________________

Hobbies/Interests: ________________

Current/Former occupation: __________

Last grade level attended: __________

Are you a:

- ☐ Student? Where: ________________
- ☐ At home caregiver? For whom: __________
- ☐ Employed? ____________________
- ☐ Disabled? Cause: ________________
- ☐ Did you move here from another country?
  Country(s): ________________
- ☐ I have an Advance Directive document

HEALTH HABITS

- ☐ Never used tobacco
- ☐ Use e-cigarettes
- ☐ Use tobacco now: Type(s) ____________; #packs/containers daily______; #years/age you started ____
- ☐ Quit tobacco: Type(s)____________Date/Age quit__________; #years used/age you started ____

Alcohol? Type(s)________________; #drinks/week________; #years/age started __________

Recreational substances? Currently using ______________________________

Formerly used ________________ Treatment required (circle)? Yes No

Exercise routine (describe)? None, or ______________________________

Special diet? ______________________________

Other regular healthcare practices?______________________________

IMMUNIZATIONS - Please write the date of your most recent vaccine (if known)

Influenza__________Tetanus__________Meningitis____________ Shingles.____________

Pneumonia__________ Have you had 2 of these? No Yes

Hepatitis A ____________ Have you completed the series of 2? No Yes

Hepatitis B ____________ Have you completed the series of 3? No Yes

HPV (Gardisil) ____________

SCREENING TESTS - Please write the date of your most recent test (if known)

Chest X-ray ____________ Colonoscopy __________ EKG ____________

Bone Density____________ Sleep study__________ Lung Function ____________

To the best of my knowledge the statements and answers on this form are true, complete and correct.

______________________________ ______________________________

Patient or Guardian's signature Date

WOMEN ONLY

Date of last menstrual period ____________________

Age your periods began ______________

Are your periods regular? Yes No

Are your periods Heavy Moderate Light

Are your cramps Severe Mild None

Date of last Pap smear _________________________

Date of last mammogram ______________________

Do you check your breasts monthly? Yes No

How many times have you been pregnant? _______

Number of deliveries: Vaginal _____ C-Section _____

Any Tubal Pregnancies? Yes No

Miscarriages Yes No

Stillbirths Yes No

Abortions Yes No

Complications with pregnancies? Yes No

Any abnormal vaginal discharge? Yes No

To the best of my knowledge the statements and answers on this form are true, complete and correct.

_______________________________ _______________________________

Patient or Guardian's signature Date

Please return to receptionist or nurse when completed and signed. Thank you

Corridor Primary Care Internal Medicine
Patient Information

Date ______________ How did you hear of us? _______________

Patient Name __________________________________ Gender: M F
Date of Birth _________________ SS # _________________________
Local Address ____
City ________________________ State ______ Zip ____________
Phone: Home ____________________ Work ______________________
Cell/Alternate ____
Permanent Address (if different):

____
City ________________________ State ______ Zip ____________

Marital Status: Single Married Divorced Widowed Partnered
Spouse/Partner Name ____________________________________
Spouse/Partner Contact # ________________________________
Parent/Guardian Name(s) _________________________________
Parent/Guardian Contact # _______________________________

Emergency Contact (other than spouse/parent)
Name ___________________________ Relation ________________
Phone ________________ Address _________________________

Race: African-American White/Hispanic Asian
Primary Ethnic group: Hispanic/Latino OR Non-Hispanic/Latino
Preferred Language(s) ___________

Is a relative a patient of this clinic? If yes, please write name:

____
I authorize CPC to share medical information with the following people:
Name ____________________ Contact # _________ Relation _________
Name ____________________ Contact # _________ Relation _________
Name ____________________ Contact # _________ Relation _________

Completed by (Sign:) ____

CORRIDOR PRIMARY CARE INTERNAL MEDICINE
601A Leah Avenue
San Marcos, Texas 78666
Gregory K. Moore, M.D.

Date:

Patient:____

Patient DOB:____________________________________

I understand that Corridor Primary Care has a Nurse Practitioner on staff.

Nurse practitioners are registered nurses with advanced academic and clinical education in family health care, pharmacology, development throughout the life cycle, and family dynamics.

FNP's provide the following care:

Physical exams
Diagnose and treat common acute illnesses
Provide management and counseling
Serve as advocates
Monitor chronic illness and conditions

I understand that I may be offered appointments for sick or well care with a nurse practitioner. I understand that I can refuse an appointment with a nurse practitioner. I understand that it is my responsibility to know if my appointment is with a physician or nurse practitioner. I agree to be treated by a nurse practitioner if I schedule an appointment with one.

____ _________________
Patient Date

CORRIDOR PRIMARY CARE INTERNAL MEDICINE
601A Leah Ave
San Marcos, Texas 78666
PHONE: (512) 396-1000 FAX: (512) 353-2554
REQUEST FOR RELEASE OF MEDICAL RECORDS

Patients Name:_____________________________ DOB: ____________

I understand that my/my child's medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law. I hereby voluntarily authorize the health information regarding the above named person to be exchanged between

From: ______________________________ To: ___________________________

Address: ____________________________ Address: _______________________

City/State/Zip: ________________________ City/State/Zip:___________________
Phone: ______________________ Phone: _____________________
Fax: ________________________ Fax:_______________________

The specific purpose(s) for this disclosure is/are:

( ) My personal Use

( ) Sharing with other Healthcare provider

( ) Other (Specify) ____

( ) I want ( ) do not want you to include information pertaining to the diagnosis and /or treatment of HIV testing, AIDS, psychiatric illness, and alcohol or chemical abuse or dependency if any.

Specific Information to be released: (Please check all that apply)

___ Complete Medical Record ____Immunization record only ___Lab/X-Ray

____History & Physicals ____Progress note ____D/C Summary

____Other _______________________________________

* I understand that I may revoke this authorization at any time by notifying the office in writing.
* I understand this authorization expires 180 days from the date signed unless otherwise revoked.
* I understand that once the above information is disclosed it may be re disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.

___________________ ____
Date Signature of patient, parent or authorized guardian

____
Print Name