HIPAA

Health Insurance Portability and Accountability Act Compliance

Tri City Psychiatric Services P.A.
5901 S. Cooper St., Ste. 131
Arlington, Texas 76017
Phone: 817-200-6680

To The Patient _____ Date _____ .

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

At Tri City Psychiatric Services, P.A., we are committed to treating and protecting health information about you responsibly. This notice describes the personal information we collect and how and when we use or disclose that information. The federal medical records privacy regulation authorizes the use and disclosure of protected health information for treatment payment and health care operations. This Notice is effective April 14, 2003 and applies to all protected heath information as defined by federal regulations.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION may be used on several bases as listed for Treatment Payment and Health Care Operations. Other uses and disclosures of your information may be used for:

- appointment reminders
- appointed care giver (family member who sees to your medical needs)
- emergency situations
- health care organization,
- to avert a serious threat to health or safety
- as appointed by law

UNDERSTANDING YOUR HEALTH INFORMATION & MEDICAL RECORDS: Each time you visit Tri City Psychiatric Services, P.A., a record of your visit is made. This record contains information abut your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data This information often referred to as your health or medical record serves as a:

- basis for planning your care and treatment
- means of communications with other health professionals involved in your care
- legal document outlining and describing the care you revived
- a tool that you or another payer (your insurance company) will use to verify that services billed were actually provided
- a source for medical research
- basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- a source of data for panning and/or marketing
- a tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information and make an informed decision when authoring the disclosure of this information to other individuals.

YOUR RIGHTS AS THE PATIENT under the federal privacy standards are as listed:

- the right to request restrictions on the use and disclosure of your protected heath information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed and the right to receive a printed copy of this notice

OUR RESPONSIBILITIES AT Tri City Psychiatric Services, P.A., are as listed:

- we are required to maintain the privacy of your health information
- provide you with this notice as to our legal rights and privacy practices with respect to information we collect and maintain abut you
- abide by the terms of this notice
- notify you if we are unable to agree to the requested restriction
- accommodate reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by law we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit, we will not use or disclose your health information without your authorization except as describe in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION for treatment. Your information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. We will use your information for payment. Your health plan may request and receive information regarding dates services provided and the medical condition being treated in order to pay for the service rendered to you. We will use your information for regular health operations. Your health information may to used as necessary to support the day-to-day activities and management of Tri City Psychiatric Services, P.A. In some instances, we have contacted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information.

PLEASE INFORM US WHEN YOU DO NOT WANT A FAMILY MEMBER OR OTHER INDIVIDUAL TO HAVE AUTHORIZATION TO RECEIVE YOUR INFORMATION.

HEALTHCARE OVERSIGHT: Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

APPOINTMENT REMINDERS: The practice may use your information to remind you about upcoming appointments. These may be sent by mail in a closed envelop, or a brief non-specific message may be left on your answering machine. If you do not approve of these methods, or, you prefer alternative methods, please inform our front office staff.

OTHER USES AND DISCLOSURES: Disclosure of your health information or its use for any purposes other then those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of you information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not effect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, PLEASE CONTACT OUR OFFICE.

If you feel your rights have been violated, please contact:

The Office for Civil Rights
U.S Department of Health & Human Services
200 Independence Avenue, S.W.
Room 50917, HHH Building
Washington D.C. 20201

To file a complaint, write to:
U.S. Department of Health & Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Tri City Psychiatric Services, P.A.,

5901 S. Cooper St., Ste.131, Arlington, TX 76017
Office (817) 200-6680 Fax (817) 200-6731

Registration Form

Last Name: First Name: Middle Initial: Male Female

Address; Apt # .

City State Zip Email

Date of Birth: Social Security # Driver's License # State: .

Home Phone: Work Phone: Ext: Cell Phone .

Marital Status: Spouse's Name: Spouse's Date of Birth: .

Patient's Employer: .

Employers Address: City: State: Zip: .

Occupation .

Primary Insurance Company:	
Policy / Member ID #	Group#
Insured:	Insured's Employer:
Insured's Social Security #	Insured's Date of Birth:

Secondary Insurance Company:	
Policy / Member ID #	Group#
Insured:	Insured's Employer:
Insured's Social Security #	Insured's Date of Birth:

Do you have any other insurance not listed above? Yes No
If yes, please provide us with additional insurance information.

In case of emergency notify: relationship to patient: .

Address: Hm phone: Wk phone: Cell phone: .

Do you have a:
1. DNR (**D**o **N**ot **R**esuscitate) Document? Yes No If yes, where is it on file? .
.
2. Living Will? Yes No If yes, where is it on file? .
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Treatment and Release of Medical Information: I hereby consent and authorize Tri City Psychiatric Services, P.A., to treat and/or release any medical information in connection with the services rendered for determination of benefits / or collection of said benefits from my health insurance carrier. I understand if my insurance does not pay due to incorrect or lack of information I have given on this form or coverage is denied, I will be responsible for any and all amounts due.

. Relationship: .
Printed Name of patient/Legal Guardian/Pryor of Account

. Date: .
Signature of patient/Legal Guardian

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(I.) I,_____, have received a copy of the HIPAA POLICY and Guidelines from Tri City Psychiatric Services, P.A.

_____ _____
Signature of patient/Legal Guardian/Pryor of Account Date

(II.) I, _____, authorize the staff at Tri City Psychiatric Services, P.A. to release my medical information to: (spouse, family, friend, son, daughter etc.)

1. _____ 2. _____

3. _____ 4. _____

._____. Date: _____.
Signature of patient/Legal Guardian

(III.) I, _____, authorize the staff at Tri City Psychiatric Services, P.A. to contact me regarding appointments, insurance and other issues pertaining to my healthcare:

Home phone:_____, Leave message: Yes No

Cell phone:_____, Leave message: Yes No

With whom may we leave a message if you are not available? _____

_____. Date:
Signature of patient/Legal Guardian

Your calls are welcome, and we will return them promptly during business hours. We do not have an after-hours answering service so you must call the office and leave a voice mail. If you need to make an appointment, please call during business hours. If you have an emergency, please call 911 or go to the nearest Emergency Room.

(IV.) I, _____, have received and reviewed a copy of the Financial Policy Agreement for Tri City Psychiatric Services, P.A. I am aware of my financial responsibility for my account regardless of insurance coverage.

_____. Date:
Signature of patient/Legal Guardian

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Financial Policy Agreement

Please read and sign this Financial Policy Agreement prior to seeing the doctor. If you have any questions about our payment policies, do not hesitate to discuss your concerns with the office manager.

In order for us to provide proper handling of your insurance claims, we ask that you inform us of any **changes in insurance coverage immediately**. If we do not have all the correct insurance information, in a timely fashion, **that visit will be self pay.**

We will assist you in obtaining reimbursement for the services we provide but it is **YOUR** responsibility to understand your healthcare network, which physicians and healthcare facilities you may use. Not all services are covered benefits in all contracts. Those not covered will be your responsibility. Please check with your insurance provider.

All co-payments, co-insurance and deductibles are due and collected prior to seeing the doctor. **If you are not prepared to pay, your appointment will be rescheduled.** All balances must be paid in a timely fashion. **There is a $35 fee for each visit balance** we must send to collections.

We accept payment by cash, VISA®, MasterCard®, Discover®, and American Express®. **WE DO NOT ACCEPT PERSONAL CHECKS. $35.00 Fee for any credit card disputed charges.**

A $50.00 fee will be applied for NO SHOW or Same Day Cancellations. We respect your time. Please respect the doctor's time.

Any payment required for labs/tests, ordered during treatment, consistent with standard of care, **are patient's responsibility.**

Please be advised that we **do not accept Medicaid, Humana, EAP Programs, HMO insurances or Tricare.**

It is **your responsibility** to confirm with your insurance if tele-health visits are covered, but i**t is still the provider's decision if they want visits to be tele-health or in person.**

Thank you for choosing us as your healthcare provider. We appreciate your trust in us and the opportunity to serve you.

Doctors / Therapists do not appear in court to defend patients / clients, if for any reason there is a subpoena the client will be responsible to pay $1,500.00 for half a day or $3,000.00 for a full day in court. Payment will need to be collected in advance.

_____	_____	_____
Printed name of patient or legal guardian	Patient/ Legal Guardian's Signature	Date

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Patient Questionnaire

SURGERIES:

MEDICATIONS:

ALLERGIES:

FAMILY HISTORY:

MEDICAL HISTORY:

PSYCHIATRIC HISTORY:

SOCIAL HISTORY:

1.) MARITAL HISTORY

2.) SIBLINGS

3.) LIVING SITUATION

4.) ABUSE – PHYSICAL, EMOTIONAL & SEXUAL

ALCOHOL:

TOBACCO:

DRUG USE:

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Patient Name: _____ Date: _____

Review of Symptoms

Headache	**Present**	**Not Present**
Dizziness	**Present**	**Not Present**
Convulsions or Seizures	**Present**	**Not Present**
Vision Problems	**Present**	**Not Present**
Hearing Problems	**Present**	**Not Present**
Smelling or Taste Problems	**Present**	**Not Present**
Thyroid Problems	**Present**	**Not Present**
Cough/Asthma	**Present**	**Not Present**
Chest Pain	**Present**	**Not Present**
Nausea/Vomiting	**Present**	**Not Present**
Abdominal Pain	**Present**	**Not Present**
Constipation	**Present**	**Not Present**
Urinary Problems	**Present**	**Not Present**
Arthritis	**Present**	**Not Present**

AUTHORIZATION FOR TRI CITY PSYCHIATRIC SERVICES, P.A. TO RECEIVE OR DISCLOSE MY PRIVATE HEALTH INFORMATION

Patient Name: _____ Previous Name: _____

Date of Birth: _____ Today's Date: _____

SSN: __-____-_____

(I.) **My authorization**

Tri City Psychiatric Services, P.A. may receive or disclose the following health information:

(Check all that applies)

{ All my health information

{ My health information related to the following treatment or condition: _____ { My health information for the dates: ____/____/_____ Other: _____

Information may be received from or disclosed to the Tri City Psychiatric Services, P.A. by:

	Name or Organization	**Phone #**	**Fax #**
1.			
2.			
3.			
4			

{ Reason for Authorization: { at my request { Other(specify) _____

{ This authorization ends on ____/____/_____

{ When the following event occurs: _____

{ When the patient terminates with Tri City Psychiatric Services, P.A.

(II.) My rights:

I understand I do not have to sign this authorization in order to get health care benefits /treatment/payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Tri City Psychiatric Services, P.A. Based upon this authorization, I may not be able to revoke this authorization if, its' purpose was to obtain insurance.

The two ways to revoke this authorization are:

1. Fill out a Revocation form. The form is available from this office.
2. Write a letter to this office.

Signature: Patient / Legal Guardian / POA	Date	Witness	Date

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