

**Administrative  
and Business Center**

9003 Airport Freeway  
Suite 300  
N. Richland Hills, TX 76180

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Hello,

On behalf of the nurses, physicians and staff of Medical Clinic of North Texas (MCNT), I would like to take this opportunity to welcome you to our group. I am delighted you chose one of our physicians to care for you or your loved ones. We are all personally committed to providing the highest quality care and exceptional customer service for you and your family.

Our network of physicians is unique to the Dallas-Fort Worth Metroplex because we focus on providing primary care through the following specialties: Pediatrics, Family Medicine, Internal Medicine, Obstetrics & Gynecology, Psychotherapy, Sports Medicine, Rheumatology, Neurology, Endocrinology, Geriatrics, Infectious Diseases, and Podiatry. This allows us the ability to serve you and your family at every stage of your lives.

With more than 100 physicians and 40 locations, MCNT physicians are conveniently located to meet your personal health care needs. In addition, we strive to be progressive in our use of Information Technologies to include electronic medical records and on-line services. Our advanced systems provide you easy access to our physicians for appointments and timely medical advice. For more information, please review our web site at [www.MCNT.com](http://www.MCNT.com). Again, thank you for choosing your Medical Clinic of North Texas physician.

Sincerely,

Karen Kennedy  
Executive Administrator



MEDICAL CLINIC OF NORTH TEXAS, P.A.
PATIENT INFORMATION FORM

PHYSICIAN'S NAME

PATIENT'S FULL NAME, MAIDEN NAME, ADDRESS, CITY, STATE, ZIP, PHONE NUMBER, EMAIL, WORK NUMBER, CELL NUMBER, PATIENT'S SOCIAL SECURITY #, SEX, MARITAL STATUS, DATE OF BIRTH, PATIENT'S EMPLOYER, EMPLOYER'S ADDRESS, SPOUSE'S/GUARDIAN'S NAME, WORK NUMBER, DATE OF BIRTH, SOCIAL SECURITY #, SPOUSE'S EMPLOYER, EMPLOYER'S ADDRESS, IN CASE OF EMERGENCY CONTACT, RELATIONSHIP, PHONE #

ETHNICITY

HISPANIC OR LATINO
NOT HISPANIC OR LATINO

PLEASE SELECT THE RACIAL CATEGORY WITH WHICH YOU MOST CLOSELY IDENTIFY WITH:

AMERICAN INDIAN OR ALASKA NATIVE, NATIVE HAWAIIAN, ASIAN OR PACIFIC ISLANDER, WHITE OR CAUCASIAN, BLACK OR AFRICAN AMERICAN, OTHER

PLEASE SPECIFY:

LANGUAGE PREFERENCE

WHAT IS THE PATIENT'S LANGUAGE OF PREFERENCE?

ENGLISH, SPANISH, OTHER, I WOULD PREFER NOT TO PROVIDE THIS INFORMATION.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the Medical Clinic of North Texas, P.A. 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 the Medical Clinic of North Texas, P.A. 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

## PATIENT HISTORY FORM

Date of first appointment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Time of appointment: \_\_\_\_\_      Birthplace: \_\_\_\_\_  
MONTH DAY YEAR

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  F  M  
STREET APT. #  
 CITY STATE ZIP Telephone: Home (\_\_\_\_) \_\_\_\_\_  
 Work (\_\_\_\_) \_\_\_\_\_

**MARITAL STATUS:**     Never Married     Married     Divorced     Separated     Widowed  
 Spouse/Significant Other:     Alive/Age \_\_\_\_\_     Deceased/Age \_\_\_\_\_     Major Illnesses \_\_\_\_\_

**EDUCATION** (circle highest level attended):  
 Grade School    7    8    9    10    11    12    College    1    2    3    4    Graduate School \_\_\_\_\_  
 Occupation \_\_\_\_\_      Number of hours worked/average per week \_\_\_\_\_

Referred here by: (check one)     Self     Family     Friend     Doctor     Other Health Professional

Name of person making referral: \_\_\_\_\_

The name of the physician providing your primary medical care: \_\_\_\_\_

Do you have an orthopedic surgeon?     Yes     No    If yes, Name: \_\_\_\_\_

Describe, briefly, your present symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date symptoms began (approximate): \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list the names of other practitioners you have seen for this problem:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please shade all the locations of your pain **over the past week** on the **body figures and hands**.

Example:

The diagram includes: a female figure with a shaded left shoulder; a male figure with a shaded right neck; a back view of a male figure with a shaded spine; a female figure with a shaded left hand; and two hand diagrams (left and right) with shaded fingers.

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment - Listening to the patient - A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999; 42 (9): 1797-808. Used by permission.

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself	Relative Name/Relationship	Yourself	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood Arthritis	<input type="checkbox"/>	Osteoporosis

Other Arthritis conditions: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

As you review the following list, please check any of those problems, which has significantly affected you.

Date of last mammogram: \_\_\_\_\_  
MONTH / DAY / YEAR

Date of last eye exam: \_\_\_\_\_  
MONTH / DAY / YEAR

Date of last chest x-ray: \_\_\_\_\_  
MONTH / DAY / YEAR

Date of last Tuberculosis Test: \_\_\_\_\_  
MONTH / DAY / YEAR

Date of last bone densitometry: \_\_\_\_\_  
MONTH / DAY / YEAR

### Constitutional

- Recent weight gain amount \_\_\_\_\_
- Recent weight loss amount \_\_\_\_\_
- Fatigue
- Weakness
- Fever

### Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

### Ears-Nose-Mouth-Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

### Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

### Respiratory

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

### Gastrointestinal

- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

### Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Sexual difficulties
- Prostate trouble

### For Women Only:

Age when periods began: \_\_\_\_\_

Periods regular?  Yes  No

How many days apart? \_\_\_\_\_

Date of last period? \_\_\_\_\_

Date of last pap? \_\_\_\_\_

Bleeding after menopause?  Yes  No

Number of pregnancies? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_

### Musculoskeletal

- Morning stiffness  
Lasting how long?  
\_\_\_\_\_ Minutes \_\_\_\_\_ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling  
List joints affected in the last 6 months.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Integumentary (skin and/or breast)

- Easy bruising
- Redness
- Rash
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

### Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

### Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

### Endocrine

- Excessive thirst

### Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/when \_\_\_\_\_

### Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

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

Date \_\_\_\_\_

Physician Initials \_\_\_\_\_

Drug allergies:  Yes  No To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PAST MEDICATIONS** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, **how long** you were taking the medication, the **results** of taking the medication and list any **reactions** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Circle Any you have taken in the past</b>					
Ansaid (flurbuprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Deldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
<b>Pain Relievers</b>					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Disease Modifying Antirheumatic Drugs (DMARDS)</b>					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysin or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Date \_\_\_\_\_

Physician Initials \_\_\_\_\_

**PAST MEDICATIONS Continued**

<b>Osteoporosis Medications</b>					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flouride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risendronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gout Medications</b>					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurfin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Others</b>					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

Have you participated in any clinical trials for new medications?  Yes  No

If yes, list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Date \_\_\_\_\_

Physician Initials \_\_\_\_\_

## SOCIAL HISTORY

Do you drink caffeinated beverages?  Yes  No

Cups/glasses per day? \_\_\_\_\_

Do you smoke?  Yes  No  Past - How long ago? \_\_\_\_\_

Do you drink alcohol?  Yes  No Number per week \_\_\_\_\_

Has anyone ever told you to cut down on your drinking?  
 Yes  No

Do you use drugs for reasons that are not medical?  Yes  No

If yes, please list: \_\_\_\_\_

Do you exercise regularly?  Yes  No

Type \_\_\_\_\_

Amount per week \_\_\_\_\_

How many hours of sleep do you get at night? \_\_\_\_\_

Do you get enough sleep at night?  Yes  No

Do you wake up feeling rested?  Yes  No

### PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Goiter            | <input type="checkbox"/> Leukemia       | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Bad headaches     | <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Colitis             |
| <input type="checkbox"/> Kidney disease    | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Psoriasis           |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Tuberculosis        |

Other significant illness (please list) \_\_\_\_\_

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

### Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures?  Yes  No Describe: \_\_\_\_\_

Any other serious injuries?  Yes  No Describe: \_\_\_\_\_

### FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

Number of children \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_ List ages of each \_\_\_\_\_

Health of children: \_\_\_\_\_

Do you know of any blood relative who has or had: (check and give relationship)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Heart disease _____       | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Epilepsy _____        | <input type="checkbox"/> Diabetes _____     |
| <input type="checkbox"/> Stroke _____   | <input type="checkbox"/> Bleeding tendency _____   | <input type="checkbox"/> Asthma _____          | <input type="checkbox"/> Goiter _____       |
| <input type="checkbox"/> Colitis _____  | <input type="checkbox"/> Alcoholism _____          | <input type="checkbox"/> Psoriasis _____       |   |

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

1. Please check (✓) the ONE best answer for your abilities at this time:

AT THIS MOMENT, are you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	_____ 0	_____ 1	_____ 2	_____ 3
b. Get in and out of bed?	_____ 0	_____ 1	_____ 2	_____ 3
c. Lift a full cup or glass to your mouth?	_____ 0	_____ 1	_____ 2	_____ 3
d. Walk outdoors on flat ground?	_____ 0	_____ 1	_____ 2	_____ 3
e. Wash and dry your entire body?	_____ 0	_____ 1	_____ 2	_____ 3
f. Bend down to pick up clothing from the floor?	_____ 0	_____ 1	_____ 2	_____ 3
g. Turn regular faucets on and off?	_____ 0	_____ 1	_____ 2	_____ 3
h. Get in and out of a car, bus, train or airplane?	_____ 0	_____ 1	_____ 2	_____ 3
i. Walk two miles?	_____ 0	_____ 1	_____ 2	_____ 3
j. Participate in sports and games as you would like?	_____ 0	_____ 1	_____ 2	_____ 3
k. Get a good night's sleep?	_____ 0	_____ 1.1	_____ 2.2	_____ 3.3
l. Deal with feelings of anxiety or being nervous?	_____ 0	_____ 1.1	_____ 2.2	_____ 3.3
m. Deal with feelings of depression or feeling blue?	_____ 0	_____ 1.1	_____ 2.2	_____ 3.3

For Office Use Only

FN

1=0.33	16=5.33
2=0.67	17=5.67
3=1.00	18=6.00
4=1.33	19=6.33
5=1.67	20=6.67
6=2.00	21=7.00
7=2.33	22=7.33
8=2.67	23=7.67
9=3.00	24=8.00
10=3.33	25=8.33
11=3.67	26=8.67
12=4.00	27=9.00
13=4.33	28=9.33
14=4.67	29=9.67
15=5.00	30=10.00

PS

PN

2. How much pain have you had because of your condition OVER THE PAST WEEK? Place a mark on the line below to indicate how severe your pain has been:

NO PAIN

PAIN AS BAD AS IT COULD BE

3. Which of the following best describes you TODAY? Please check (✓) only one:

- \_\_\_\_\_ 1. I can do **everything** I want to.
- \_\_\_\_\_ 2. I can do **most** of the things I want to do, but have **some** limitations.
- \_\_\_\_\_ 3. I can do **some**, but not all, of the things I want to do, and I have **many** limitations.
- \_\_\_\_\_ 4. I can do **hardly any** of the things I want to do.

4. When you get up in the morning, do you feel stiff? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answer "No," please go to Item 6.

5. If you answer "Yes," please write the number of minutes: \_\_\_\_\_, OR number of hours: \_\_\_\_\_ until you are as limber as you will be for the day?

6. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Place a mark on the line below:

FATIGUE IS NO PROBLEM

FATIGUE IS A MAJOR PROBLEM

FT

7. How do you feel TODAY compare to TWO WEEKS AGO? Please check (✓) only one:

- \_\_\_\_\_ 1. Much better today than two weeks ago.
- \_\_\_\_\_ 2. Better today than two weeks ago.
- \_\_\_\_\_ 3. The same today as two weeks ago.
- \_\_\_\_\_ 4. Worse today than two weeks ago.
- \_\_\_\_\_ 5. Much worse today than two weeks ago.

8. How SATISFIED are you with your ability to do your usual activities? Please check (✓) only one:

- \_\_\_\_\_ 1. Very Satisfied
- \_\_\_\_\_ 2. Somewhat Satisfied
- \_\_\_\_\_ 3. Somewhat Dissatisfied
- \_\_\_\_\_ 4. Very Dissatisfied

9. Considering all the ways in which illness and health conditions may affect you at this time, please place a mark below to show how you are doing.

VERY WELL

VERY POORLY

GL

**CONSENT FOR TREATMENT**

**DATE TODAY:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
LAST FIRST M.I.

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 the Medical Clinic of North Texas, P.A. 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 the Medical Clinic of North Texas, P.A.'s 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 the Medical Clinic of North Texas, P.A. if any of these situations occur during your treatment period.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**DATE TODAY:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
 LAST FIRST M.I.

Thank you for choosing the Medical Clinic of North Texas, P.A. (MCNT) 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.**

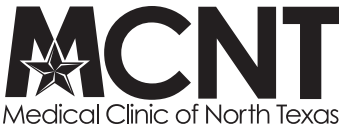
- **It is your responsibility to provide us with your most current insurance information.**
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must 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 the Medical Clinic of North Texas, P.A. 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 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

\_\_\_\_\_  
EPM Medical Record Number



# RED FLAGS PAYMENT PERMISSION FORM

To be completed by the person whose name appears on the Form of Payment.

I, \_\_\_\_\_, give permission for,  
(Name of person on form of payment)  
\_\_\_\_\_, to use my Medical  
(Printed name of patient)

Flex card, personal credit card, or personal check to pay for the services that they receive at the Medical Clinic of North Texas.

Please provide the last **4 digits** of the card number or bank account that will be used for transactions.

\_\_\_\_\_  
FlexMed Card

\_\_\_\_\_  
Expiration Year

\_\_\_\_\_  
Credit Card

\_\_\_\_\_  
Expiration Year

\_\_\_\_\_  
Bank Account

I understand that the information provided in this document will remain in effect until expiration dates indicated above or until written letter is provided to the Medical Clinic of North Texas to either void or terminate this agreement.

\_\_\_\_\_  
Guarantor's Printed Name

\_\_\_\_\_  
Dependent's Name

\_\_\_\_\_  
Guarantor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **What is NextMD?**

**NextMD** is a patient portal service that eliminates time-consuming phone calls and allows you, the patient, on-line access to your physician's office. All requests or questions will be answered within 24 hours. With respect to system security, unlike emails that use multiple servers over the internet, the **NextMD** technology allows your doctor to use a single server secured by both a firewall and 128-bit encryption to safeguard your privacy. This secured system operates by a password protected log-in that you receive upon registering for the service. Only you will have access to your information. Each family member will receive their own log-in code and password. If the patient is under 18 years of age, the responsible parent will receive the enrollment code and password information.

### **Benefits of NextMD**

With NextMD, you can access a wealth of general health information online, view new messages from the practice or take advantage of these many powerful benefits:

- Access and request personal or general information.
- Receive and review Lab Results within days of the testing.
- Request a non-urgent appointment or confirm an appointment. For all urgent issues, we ask that you call our office.
- Request medication refills.
- Receive documents from your doctor such as immunization records, return to work/school forms, lab result cards, and visit summaries.
- Receive important notifications such as drug recalls or guidance, tailored to your specific health plan, chronic conditions, and disease management.
- Many new features, such as the ability to fill out forms and pre-visit questionnaires, and online doctor visits are on the horizon.
- No health information is sent via email. When a message is sent from the doctor's office, you receive an email stating you have a new message from **Medical Clinic of North Texas** and are directed to log in to **NextMD** to review.

### **How Do I Sign Up?**

There are 2 ways for you to register for NextMD.

#### **Option 1:**

- Simply provide your email address at check-in today.
- You will receive a temporary enrollment token.
- Sign on to our website at [www.mcnt.com](http://www.mcnt.com) and click the NextMD button located at the top right corner of our homepage, enter your enrollment token and then follow the instructions.

#### **Option 2:**

- Call our Customer Service Line at 1-800-555-1429, press option 3, and a helpful member of our staff will assist you in registering for NextMD.

We are very excited about providing this service to you. Your health and well-being are our number one priority. Be sure to sign up today.

Please keep this for  
your records.



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
TO THE MEDICAL CLINIC OF NORTH TEXAS, P.A.**

**DATE TODAY:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
LAST FIRST M.I.

I, \_\_\_\_\_, hereby authorize  
(Name of patient or legal representative)

\_\_\_\_\_  
(Name of person/entity who should release records)

\_\_\_\_\_  
(Address of person who should release records)

to release the following information by mail, fax, electronically or orally to:

**Medical Clinic of North Texas, P.A.**  
**Frisco - Rheumatology**  
Address: 2595 Dallas Parkway, Suite 405  
Frisco, Texas 75034  
Phone: (972) 377-2732 Fax: (972) 377-1499

**Information is for:**  
 Dr. Dipali S. Kapoor

From the health records of: \_\_\_\_\_  
(Name of person/entity who should release records)

For the purpose of: \_\_\_\_\_

- All Records
- Statements of Charges or Payments
- AIDS or HIV Information
- History and Physical Examination
- Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- Record of visit for a specific date(s). Specific dates include or are limited to:
- Mental Health and/or Alcohol and Drug Abuse Treatment
- Progress Notes
- Discharge Summary
- Consultation Reports
- Hepatitis Information
- Photographs, Videotapes, Digital, or Other Images

Other (must be specific): \_\_\_\_\_

**This authorization is given freely with the understanding that:**

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. The Medical Clinic of North Texas, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Expiration Date of Authorization

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DATE TODAY: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE: \_\_\_\_\_  
LAST FIRST M.I.

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand the Medical Clinic of North Texas, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, www.MCNT.com, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Expiration Date of Authorization

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**I wish to be contacted in the following manner:**

**Home Telephone**

- Ok to leave message with detailed information
- Leave message with call-back number only

**Work Telephone**

- Ok to leave message with detailed information
- Leave message with call-back number only

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 Medical Clinic of North Texas, P.A. to share my protected health information with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

**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 **Medical Clinic of North Texas, P.A.** 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 Medical Clinic of North Texas, P.A. 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 **Medical Clinic of North Texas, P.A.** 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:

**Medical Clinic of North Texas, P.A.**

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 office visit copay?

---

9. Do I have preventive/well woman coverage?

---

Is there anything that is NOT covered?

---

10. How often can I have a preventive physical/well woman visit?

---

11. Is there a copay for preventive physical/well woman visit?

---

12. Is there a cost limit on my preventive coverage?

---

If so, how much?

---

13. Is there a copay if I have labs or procedures done without seeing the physician or physician assistant?

---

14. 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?

---

15. Is there a cost limit on my preventive coverage?

---

If so, what is that limit?

---

16. Do I have coverage for preventive immunizations?

---

Travel Immunizations?

---

Is there a co-pay when I go to the doctor for immunizations only?

---

17. 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.

### **What is HIPAA?**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law passed by Congress to protect patient privacy with regards to medical records and to control the flow of health information. Also, HIPAA was designed to lower administrative costs by setting standards for the filing and processing of insurance claims. HIPAA regulations will affect people at all levels of healthcare, including patients and their physicians.

### **What is TPO?**

Treatment, payment, and operations (TPO) include the routine processes involved in receiving healthcare. There are several examples that encompass TPO. Oftentimes it is necessary to share your health information between healthcare providers, such as providing a referral to a specialist. This is a part of **treatment**. Information about your diagnosis and other health information is required for **payment** from insurance companies. Evaluations of medical records to ensure high quality care provided by our physicians are considered part of **operations**.

### **Why should I care about TPO?**

HIPAA legislation outlines significant differences for the handling of health information for TPO and reasons *other* than TPO. The laws created by HIPAA are designed to expedite healthcare by placing no restrictions on the sharing of your health information for TPO and severely restricting information not required for TPO (e.g. releasing information to other people, even your family members, or for marketing reasons).

### **How will HIPAA affect me as a patient?**

HIPAA will benefit patients in many ways. For example, the Medical Clinic of North Texas, P.A. will provide all patients with information about their rights to privacy. Also, the new regulations make it illegal for healthcare providers to sell your health information to marketers and advertisers without your written authorization. As a patient, you have the right to review your medical record if you believe something is incorrect and request a change. However, only your physician can determine if your medical record is inaccurate.

### **Will HIPAA have any negative effects?**

The intention of HIPAA legislation is to improve the level of privacy for patients.

***However, the law requires the patient's written permission before his or her health information can be released for reasons other than TPO. For example, relatives can not call to the clinic and get any health information without you signing an authorization first. Please understand the clinic is working to protect the privacy of all patients and may have stricter policies for the release of such information.***

### **When will these changes take place?**

The Medical Clinic of North Texas, P.A. must comply with HIPAA regulations by April 14, 2003. However, every clinic is working diligently to become compliant prior to the deadline.

### **Who should I contact if I have concerns about the privacy of my MCNT medical record?**

The Medical Clinic of North Texas, P.A. has a Privacy Officer available to resolve any privacy issues. Please contact:

David D. Russell, M.D.  
Medical Clinic of North Texas, P.A.  
9003 Airport Freeway, Suite 300  
North Richland Hills, Texas 76180  
(817) 514-5200

Thank you for helping the Medical Clinic of North Texas, P.A. in our efforts to protect the privacy of ALL our patients!

Please keep this for  
your records.