Oak Hills
FAMILY PRACTICE

Dear Patient:

Welcome to Oak Hills Family Practice, for the past 10 years we have been an independent provider of primary care medicine. We are excited you have chosen us to be your primary care provider and are committed to providing you with quality and affordable care. Our hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health.

As the patient, you also share in your personal healthcare, the following is a statement of our office and financial policies. Your clear understanding of our policies is important to our professional relationship. Please read and sign prior to treatment. **If you have any questions about our office and/or financial policy, please ask one of our staff members.**

We look forward to working with you as your family doctor. Let's work together to help you live the satisfying life that you deserve. Our hope is that you will enjoy your visit and recommend us to your friends and family in the future.

Sincerely:
Oak Hills Family Practice

OFFICE POLICY

1. Office Hours: Our office hours are Monday-Thursday 8:00 am to 5:00 pm and Friday 8:00 am to 12 noon. We also close in observance of the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas.

2. Appointments: Oak Hills Family Practice requires patients 18 years and older to schedule their own appointments. Appointments for minors must be scheduled by the parent or legal guardian; the minor must also be accompanied by their parent or guardian to each visit.

3. Appointment Times: We set aside times in the morning and afternoon for sick acute appointments and make every effort to schedule you when you are sick. Arriving promptly for your appointment is not only a courtesy, but a consideration to those patients whose appointments are scheduled after yours. If you must cancel or reschedule an appointment, we require a 24-hour notice.

4. Same-day wellness care and illness care: Unfortunately, because of many insurers' payment policy, we may have to complete your wellness care and your illness care in two separate visits. If you have a health problem you want to discuss with your doctor during your well visit, the doctor may decide to treat that problem and ask you to schedule another appointment for your well visit.

5. Communications: In order for us to see patients at their scheduled appointment time, it may not be possible to answer your phone calls immediately. In that regard, you may be asked to leave a voice mail message for one of our staff. Calls received before 3 pm will be returned the same day; calls received after 3 pm may be returned the following business day.

If you have access to a computer our staff can respond to a messages through our patient portal. Using the patient portal will most likely ensure a shorter response time to your questions. To access the web portal go to the following web address: https://webview.EMDS.com/shortfamilymedical

6. After Hours: If you would like to speak to someone when the office is closed, you may leave a message in the Emergency Message Center. We do not prescribe medications over the phone nor do we refill medications at night or on weekends.

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FINANCIAL POLICY

1. Payment for Services. We are striving to keep our administrative costs at a minimum so we can keep our fees low. Please understand that payment for healthcare services is considered ***a part of your treatment***. We accept cash, checks, Visa, and MasterCard. All co-payments and deductibles must be paid at the time of service.

If you are not paying 100% of your services on the date of your visit, we require a credit card to be left on file. This arrangement is part of your contract with your insurance company. Your credit card information is electronically held in a secure file and after your insurance processes your claim the remaining amount will be charged to your card.

2. Insurance: At each visit, patients must provide a copy of your driver's license and current insurance card. If you are insured we will do our best to verify your coverage prior to your visit. If we cannot confirm your coverage is active payment in full is expected at the time of service. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

3. Claims submission. We will submit your claims and assist in getting your claims paid. Your insurance company may need information from you, it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. The remaining balances due after your insurance processes your claim will be charged to the credit card we have on file.

4. Minors. For children under the age of 18, an adult is responsible for payment. In addition, minors cannot receive medical treatment without the written consent of a parent or legal guardian

5. Nonpayment. If your account is over **60 days past due**, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless arranged in advance and a signed payment plan is in place. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

6. Missed appointments. Our policy is to charge $35 for follow up appointments and $75 for physicals and/or scheduled procedures missed or cancelled without 24-hours advance notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

By signing below, I hereby certify that I have read and understand the office and financial policies and agree to abide by their guidelines.

_____ _____

Signature of patient or responsible party **Date**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the **OAK HILLS FAMILY PRACTICE** may decline to provide treatment to me.

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PATIENT REGISTRATION FORM

PLEASE PRINT

TODAY'S DATE: _____

- **PATIENT'S** NAME _____
  Last First M.I.

HOME ADDRESS _____

CITY, STATE, ZIP _____ GENDER ☐ MALE ☐ FEMALE

RACE: ☐ Asian ☐ Black/African American ☐ White ☐ Hispanic or Latino ☐ Other: _____

ETHNICITY: ☐ Hispanic or Latino ☐ NOT Hispanic or Lanitino

PREFERRED LANGUAGE: ☐ English ☐ Spanish

BIRTH DATE _____ MARITAL STATUS _____

CELL_____ **HOME** _____ **WORK** _____

EMERGENCY CONTACT NAME & PHONE # _____

PHARMACY PHONE # & ADDRESS _____

(please include cross streets if address is unknown)

_____

_____

Oak Hills Family Practice communicates with our patients through a secure online patient portal. Your email address will be required and will only be used for important communications between you and our staff.

- **EMAIL ADDRESS** _____

I hereby grant permission to Oak Hills Family Practice to perform medical services as deemed necessary by my healthcare provider. I authorize the holder of medical or other information to release any documents required by my insurance carrier, governmental agency, or its intermediary as related to my treatment. I agree to pay any charges incurred by me to Oak Hills Family Practice.

_____

SIGNATURE OF PATIENT OF RESPONSIBLE PARTY

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INFORMATION

PRIMARY INSURANCE NAME: _____

ID # _____

GROUP # _____

ADDRESS: _____

SECONDARY INSURANCE NAME: _____

ID # _____

GROUP # _____

ADDRESS: _____

PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS THE GUARANTOR ON YOUR INSURANCE PLAN

_____
NAME OF GUARANTOR RELATIONSHIP

_____
DATE OF BIRTH SOCIAL SECURITY NUMBER

IF THE PATIENT IS A MINOR PLEASE COMPLETE PARENTAL INFORMATION

■ ***GUARDIAN'S NAME*** _____

SOCIAL SEC # _____ DOB:_____

ADDRESS _____

CITY, ST, ZIP _____PRIMARY PHONE # _____

Please note: The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.

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PRIVACY PRACTICES

- **CONTACTS:** Please list other persons that we may inform about your health information. Be aware that these people will have full access to your entire medical record.

_____ _____

_____ _____

- **PHONE NUMBERS:** Which phone numbers would you like to receive calls about appointment, financial or medical condition information? ***[check all that apply]***
  ☐ Home Phone ☐ Cell phone ☐ Work Phone ☐ Other Phone: _____

- **VOICE MAIL:** May we leave financial or medical information such as lab results on your answering machine?

  ☐ Yes ☐ No

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

As a patient of Oak Hills Family Practice you have been given a copy of our Privacy Practice policy. After reading the policy please sign below your acknowledgement of receipt. Should you have any questions regarding the information in our Notice of Privacy Practices, please speak with our staff and they will be happy to address your questions and/or concerns.

I, _____, have received a copy of the Oak Hills Family Practice Notice of Privacy Practices. I understand, unless I object in writing, that my health information can be disclosed for any of the outlined reasons given in the Notice of Privacy Practices dated **12/13/2013**.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Please print the name of the patient Patient DOB

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NOTICE OF PRIVACY PRACTICES

Oak Hills Family Practice

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. 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. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS

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 that physician, 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 we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services 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. Examples include, "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 "we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care."

B. DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

There are situations in which we are permitted 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 that rely 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.

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Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations 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:

1. The information is released pursuant to legal process, such as a warranty or subpoena;
2. The information pertains to a victim of crime and you are incapacitated;
3. The information pertains to a person who has died under circumstances that may be related to criminal conduct;
4. The information is about a victim of crime and we are unable to obtain the person's agreement;
5. The information is released because of a crime that has occurred on these premises; or
6. The information is released to locate a fugitive, missing person, or suspect.

We also may 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 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 person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

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

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C. YOUR RIGHTS UNDER FEDERAL LAW

The U.S. 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 patients who exercise 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 health care 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.

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

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 at the end of this document.

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 at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

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

1. The information is psychotherapy notes.
2. The information reveals the identity of a person who provided information under a promise of confidentiality.
3. The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
4. The information 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 arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you 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 for providing copies or a narrative.

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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 at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

1. The information was not created by this practice or the physician/s or any practitioner in this practice.
2. The information is not part of the designated record set.
3. The information is not available for inspection because of an appropriate denial.
4. 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 now have the correct information.

Accounting of Certain Disclosures
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 at the end of this document. 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 charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER BENEFITS
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.

E. 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 U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. 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.

G. 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:

Name of Privacy Officer:	Hope Short, M.D.
Mailing Address:	2756 Elkton Trail Tyler, TX 75703-0723
Phone Number:	(903) 534-0911
Fax Number:	(903) 534-8882

This notice is effective December 11, 2013

You are invited to our Web Portal here at Oak Hills Family Practice.

By accessing the web portal, you will be able to view upcoming appointments and lab results.
You should automatically receive an invite that looks something like this! Please call us if you do not receive an invite to log into the patient portal.

Your username will be your email address, and you will be given a temporary password. SEE BELOW

OAK HILLS FAMILY PRACTICE <dnr@myupdox.com>

New Portal Account with OAK HILLS FAMILY PRACTICE

This message is for PATIENT NAME

OAK HILLS FAMILY PRACTICE has created a website where you can securely communicate with them.

A new patient portal has been set up for our patients at Oak Hills Family Practice. This is a convenient and timely way for patients to be able to communicate with our staff and receive a speedy response.
Once logged in, you can communicate with the staff by selecting the messages button on the left and click on SEND MSG button at top. Under the words new message there will be a box that is blank with a drop-down arrow. You will click on the drop-down arrow to select nurse if it is a clinical question or receptionist if it is a scheduling or billing question.

Thank you for using the portal.

Use the following link and information to access your new account:

1. Go to the website https://oakhillsfamilypractice.mymedaccess.com
2. Enter your login information
   - initial username: testmom@gmail.com (Pt. 's email address)
   - initial password: Crimson-12-Baseball