Medical Clinic Patient Intake

totalcare Your Medical Home

☐ New Patient ☐ Existing Patient

PATIENT INFORMATION:

Last	Middle	First	Gender:
DOB:	Email:		
Address:	City State Zip		
Cell Phone:	Home Phone:	Work Phone:	
Guardian Name:	Guardian Relationship:		
Guardian DOB:	Guardian Phone #:		
SSI#:	Race:	Ethnicity:	
Marital Status:	Spouse Name:		
Primary Care Physician:	Physician's #:		

INSURANCE INFORMATION:

Are you the primary insured: ☐ Yes ☐ No Relationship With Primary:

Insurance Subscriber: Subscriber DOB:

Subscriber SSI#: Employer:

Insurance: Type: HMO PPO POS HSA Medicare Other:

Copay/Co-Insurance: Deductible: Group #:

REASON FOR VISIT:

☐ Illness ☐ Injury ☐ Weight Loss ☐ Annual Physical

☐ Workman's Comp ☐ OccMed ☐ Pre-Employment Screening

☐ Testosterone ☐ IV Hydration

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EMERGENCY CONTACT:

Name: Relationship: Number:

Address: City State Zip

HOW DID YOU HEAR ABOUT US:

☐ Location ☐ Signs ☐ Internet ☐ Email ☐ Referral ☐ Print Advertising ☐ Social Media

Employer: Physician Referral:

School: Pharmacy:

Daycare: Insurance:

SIGNATURE:

Patient Name (Print):

Signature: Date:

THANK YOU FOR CHOOSING TOTAL CARE! FOLLOWING YOUR VISIT WE WOULD LIKE TO SEND YOU A SHORT SURVAY AND HELP SET YOU SET UP YOUR PATIENT PORTAL.

INSURANCE RELEASE INFO:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for the payment and to obtain reimbursement of any claim. I request that payment of authorized benefits be made on my behalf. I assign that benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as vailed as an original. I understand I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE:

Patient Name (Print):

Signature: Date:

HIPAA NOTICE OF PRIVACY PRACTICES

This notice descries how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

TOTAL CARE BRIDGE CITY
1650 TEXAS AVENUE BRIDGE CITY, TX 77611

If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

SUMMARY

In order to provide you with benefits, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that if Total Care receives personal information about health, from you, your physician, hospitals, and other provide you with health care services we are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasion on which we may disclose this information to others.

KINDS OF INFORMATION TO WHICH THIS NOTICE APPLIES

This notice applies to individually identifiable protected health information that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or past, present, or future payment for the provision of health care to an individual; and identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify' the individual (hereinafter referred to as "protected health information").

POLICIES AND/ OR RIDERS AFFECTED BY THIS NOTICE

The following policies and/or riders and any combination thereof, provided by Total Care are subject to the privacy policies and procedures set forth in this notice: cancer insurance; medical expense insurance; health indemnity insurance; hospital indemnity insurance; dental insurance; long term care insurance; flexible health care spending accounts; Medicare Supplement insurance, vision insurance; medical expense reimbursement plans; and any other coverages offered by us that meet the definition of health plan contained in the HIPAA Privacy Rule.

The following policies and/or riders, and any combination thereof, provided by Total Care, and other coverages that do not meet the definition of a health plan contained to the HIPAA Privacy Rule are not covered under this notice: disability income insurance; accidental death and dismemberment insurance; life insurance; annuity plans; Roth individual retirement accounts; simplified employee pension plans; and excess loss coverage on Self-Funded Health Plans.

WHO MUST ABIDE BY THIS NOTICE

All employees, staff, students, volunteers and other personnel whose work involves one of the products covered under this notice and who are under the direct control of Total Care must abide by this notice. The people and organizations to which this notice applies (referred to as "we,""our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of payment and operations activities as described below.

OUR LEGAL DUTIES

We are required by law to maintain the privacy of your protected health information.
We are required to abide by the terms of notice that is currently in effect.

OUR RIGHT TO CHANGE THIS NOTICE

Reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any protected health information, which we already have, as well as to protected health information we receive in the future. Before we make any material change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all named insureds then covered by a product subject to the notice within 60 days of the effective date.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use your protected health information, or disclose it to others, for several different reasons. This notice described these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Payment
We will use your protected health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our claim- processing department may use your protected health information to pay your claims. We will also send you information about claims we pay and claims we do not pay (called an (explanation of benefits"). The explanation of benefits will include information about claims we receive for Insured and each dependent who are enrolled together under a single contact or identification number. Under certain circumstances, you may receive this information confidentiality: see the "Confidential Communication" section in this notice. We may also disclose some of your protected health information to companies with whom we contact for payment-related services. For instance, if you own us money, we may give information about you to collection company with whom we contact to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

2.Health Care Operation
We may use and disclose your protected health information for activities that are necrosis operate this organization. This includes reading your protected health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may disclose your protected health information as necessary to others with whom we contract to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

3. Legal Requirement to Disclose Information
We may use or disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your protected information, and the information of others, if we are audited by the state insurance department. We will also disclose your protected health information when we are required to do so by a court order or other judicial or administrative process.

4. Public Health Activities
We will disclose your protected health information when required to do so for public health purposes. This includes certain diseases, births, deaths, and reactions to certain medications. It also includes reporting certain information regarding products and activities regulated by the federal Food and Drug Administration. It may also include notifying people who have been exposed to a disease.

5. To Report Abuse
We may disclose your protected health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws require or allow such reporting, or with your permission.

6. Government Oversight
We may disclose your protected health information if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.

7. Judicial or Administrative Proceedings
We may disclose your protected health information during a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).

8. Coroners
We may disclose your protected health information to coroners, medical examiner, and/or funeral directors consistent with the law.

9. Worker's Compensation
We may disclose your protected health information to worker's compensation agencies if necessary, for your worker's compensation benefits determination.

10. Limited Data Sets
We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets.

11. Specialized Purposes
We may use or disclose the protected health information of members of the armed forces as authorized by military command authorities. We may disclose your protected health information for several other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your protected health information for national security, intelligence, and protection of the president.

12. To Avert a Serious Threat
We may disclose your protected health information if we decide that disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

13. Family and Friends
We may disclose your protected health information to a member of your family or to someone else that is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose you information to family or friends if you object.

MORE STRINGENT LAW

1. Authorization
We may use or disclose your protected health information for any purpose that listed in this notice without your written authorization. We will not use or disclose your protect health information for any other reason without your written authorization. If you authorize us to use or disclose your protected health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your protected health information, or about how revoke an authorization, contact the person listed under "Whom to Contact" at the end of the notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the policy or the policy itself.

2. Request Restrictions
You have right to request restrictions on certain of our uses and disclosures of your protected health information for insurance payment or health care operation, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your protected health information to spouse. Your request must describe in detail the restriction you are requesting. We will consider your request. But we are not required to agree. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication
If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanation of benefits that contain your protected health information to different address rather than your home. Or you may ask us to speak to you personally on the telephone rather than sending your protected health information by mail. We will agree to any reasonable request. Request for confidential communication must be in writing it must state that disclosure of the protected health information could endanger you; it must be signed by you or your representative and sent to us at the address under "Whom to Contact" at the end of the notice.

4. Inspect and Receive a Copy of Protected Health Information
You have right to inspect certain protected health information about you that we have in our records, and to receive copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make a request in writing, you must state that you are requesting access to your protected health information and either or representative must sign the request. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact us at the address under "Whom to Contact" at the end of this notice. We may deny you access to certain information. If we do, we will give you the reason, in "Writing." We will also explain how you may appeal the decision.

5. Amend Protected Health Information
You have the right to ask us to amend protected health information about you, which you believe is not correct, or not complete. If you want to request that we amend your protected health information you must make this request in writing, it must be signed by either you or your representative, and give us the reason you believe the information is not correct or complete. Your request to amend your information must be sent to the address under "Whom to Contact" at the end of this notice. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures
You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your protected health information to others. The list will include dates of the disclosures, names of the people or organizations to whom the information was disclosed, a description of the information, and due reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. To be considered, your accounting request must be in writing, signed by you or your representative and sent to the address under "Whom to Contact" at the end of this notice.

7. Complaints
You have right to complain about our privacy practices, if you think your privacy have been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Texas Department of Insurance. All complaints must be in writing, must describe the situation giving rise to the complaint and must be filed within 180 days of the date you know, or should have known, of the event giving rise to the complaint. You will not be subject to any retaliation for filling a complaint.

WHOM TO CONTACT:
Contact the Front Office for questions concerning

- information about this notice
- information about our privacy policy
- If you want to exercise any of your rights, as listed on this notice

TOTAL CARE - BRIDGE CITY:
1650 Texas Avenue Bridge City, Tx 77611
1-833-MYTOTAL

SIGNATURE:

Patient Name (Print):

Signature: Date: