THE VAZ CLINIC, PA.
URGENT CARE
TVC CLINICAL RESEARCH

Mon - Fri. & Holidays 8 a.m. - 8 p.m.
830-672 -2424
1103 N. Sarah DeWitt Dr. • Gonzales, Tx 78629
Veteran Owned and Oparated
Garth O. Vaz, M.D.

PATIENT DEMOGRAPHICS

Date: _____

First Name: _____ **Last Name**: _____ **MI**: ____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Email: _____

Home Phone: ( ) _____--_____ **Work Phone**: ( ) _____--_____

Cell Phone: ( ) _____--_____

DOB: _____ **Social Security Number**: ___-___--____

Gender: Male / Female **Marital Status**: ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Employer: _____ **Occupation**: _____

Address: _____ **City/St/Zip**: _____

Spouse/Parent's Name: (if patient is a minor) _____

Referred by whom: _____

Emergency Contact: _____

Relation to Patient: _____ **Phone**: ( ) _____--_____

INSURANCE INFORMATION

Please Provide Insurance Card(s) and Photo ID to the Receptionist

Insured's Name: (If different from patient) _____

DOB: _____ **Social Security #**: ___-___--____

Primary Insurance Name: _____

Policy #: _____ **Group #**: _____

Secondary Insurance Name: _____

Policy #: _____ **Group #**: _____

I certify the above information is correct. I authorize The Vaz Clinic, P.A. to release or request medical information necessary to process health insurance claims. I authorize assignment of benefits on my medical insurance claims to The Vaz Clinic, P.A. I understand that I will be responsible for payment at the time that services are rendered. I will be responsible for any deductible and/or coinsurance or copays due The Vaz Clinic, P. A. can provide itemized receipts upon request.

Patient Signature: _____ **Date**: _____

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MEDICAL INFORMATION

Is this a Work-Related Injury? ( ) Yes ( ) No

Is this related to an auto accident? ( ) Yes ( ) No

If Yes, see the receptionist BEFORE your appointment

What are you being seen for today?

_____

MEDICAL HISTORY

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY

Patient Name: _____ DOB: _____

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so.

Please state briefly the problems that have brought you to the doctor's office today:

_____

PERSONAL INFORMATION

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Children: ( ) Yes ( ) No If yes, How many? _____

Any problems with their health and if so, who and what?

_____

Smoking: ( ) Yes ( ) No If yes, How many packs per day? _____ How long? _____

Alcohol: ( ) Yes ( ) No If yes, How much? _____ How frequently? _____

Illicit or Frequent Drug Use: ( ) Yes ( ) No If yes, ( ) Ongoing ( ) Past Use

Which substance(s):_____

Do you have any of these conditions or any other problems that you want the doctor to know about?

( ) Problems with Vision
( ) Problems w/ chewing or swallowing
( ) Shortness of breath: asthma/emphysema
( ) Swelling of feet or hands
( ) Mitral Valve Prolapse
( ) Other: _____

( ) Problem with hearing
( ) Heart Murmur
( ) Urinating at night
( ) Heart beating fast
( ) Elevated Cholesterol

( ) Hemorrhoids
( ) Chest Pains
( ) Heart skipping
( ) Pain when urinating
( ) Migraines

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Patient Name: _____ DOB: _____

Patient's Surgical History

Surgeries:	*Date:*	*Surgeries:*	*Date:*
( ) Tonsils	_____	( ) Heart	_____
( ) Hernia	_____	( ) Broken bones	_____
( ) Adenoids	_____	( ) Gall Bladder	_____
( ) Knee replacement	_____	( ) Hysterectomy	_____
( ) Vein Stripping	_____	( ) C-section	_____
( ) Hip replacement	_____	( ) Ovaries	_____
( ) Urinary bladder	_____	( ) Tubal Ligation	_____
( ) Lungs	_____	( ) Colonoscopy	_____
( ) Stomach or Intestines	_____	( ) Appendix	_____
( ) Hemorrhoids	_____		

Past Medical

(Have you had any of the following?)

	Date:		*Date:*		*Date:*
( ) Pneumonia	_____	( ) Lung Disease	_____	( ) Hypertension	_____
( ) Chest Pain	_____	( ) Acid reflux	_____	( ) Diabetes	_____
( ) Stroke	_____	( ) Hyperthyroidism	_____	( ) Kidney Disease	_____
( ) Cancer	_____	( ) Gout	_____	( ) Migraines	_____
( ) Peptic Ulcer	_____	( ) Liver Disease	_____	( ) Hepatitis	_____
( ) Jaundice	_____	( ) Diverticulitis	_____	( ) Irritable Bowel Syndrome	_____
( ) Colon Polyps	_____	( ) Hypothyroidism	_____	( ) Inflammatory Bowel Disease	_____

Family History

(Please check those that apply and identify which family member)

(F)Father, (M) Mother, (B) Brother, (S) Sister, (MAT GF) Maternal Grandfather, (PAT GF) Paternal Grandfather, (MAT GM) Maternal Grandmother, (PAT GM) Paternal Grandmother

( ) Hypertension	_____	( ) Diabetes	_____	( ) Ulcerative Colitis	_____
( ) Renal Disease	_____	( ) Arthritis	_____	( ) Peptic Ulcer Disease	_____
( ) Cancer	_____	( ) Lung Disease	_____	( ) Inflammatory Bowel	_____
( ) Heart Disease	_____	( ) Gallstones	_____	( ) Irritable bowel syndrome	_____
( ) Thyroid Disease	_____	( ) Liver Disease	_____	( ) Gout	_____
( ) Leukemia	_____	( ) Tuberculosis	_____	( ) Chrons Disease	_____
( ) Heart Attack	_____	( ) Epilepsy	_____	( ) Other:	_____
( ) Goiter	_____	( ) Colon Polyps	_____	_____	
( ) Hepatitis	_____	( ) Migraines	_____	_____	
( ) Stroke	_____	( ) Emphysema	_____		

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Patient Name: _____ DOB: _____

Current Immunizations

	Date:		*Date:*		*Date:*
( ) TD/Tdap	_____	( ) MMR	_____	( ) Pneumonia	_____
( ) HEP B	_____	( ) HPV	_____	( ) Chicken Pox	_____
( ) HEP A	_____	( ) Meningitis	_____	( ) Flu	_____

Medications

(List all medications you are currently taking, including over the counter and prescriptions, and dosage)

Aspirin: _____ Tylenol: _____ Hormones/Birth Control: _____

Arthritis Medication: _____ Blood Pressure: _____

Antacids: _____ *(including; Tums, Rolaids, Alka-Seltzer, Maalox, Mylanta, Riopan, Digel, Aamphojel, Alternagel, or Gaviscon)*

Other:_____

_____

_____

_____

Allergies

Are you allergic to any medications? ( ) YES ( ) NO If Yes, please list:

_____

Other non-medication allergies? ( ) YES ( ) NO If Yes, please list:

_____

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Pysician Assistant / Nurse Practitioner Consent for Treatment

This practice may have a physician assistant or/and a Nurse Practitioner on staff to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical service provided.

A physician assistant may provide medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting with surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and understand that, from time to time, I may be asked to see a physician assistant but will not be required to do so. I understand that, at any time, I can refuse to see the physician assistant and request to see a physician. However, I understand that if I elect NOT to see a physician assistant, I will not be able to schedule my appointment until the physician is available.

_____ _____

Patient Name (Print): Date:

_____ _____

Patient Signature: Witness: (If applicable)

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THE MEDICAL OFFICE OF
THE VAZ CLINIC, P.A.
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to The Medical Office of The Vaz Clinic, P.A. including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. **Quality Assurance.** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. **Utilization Review.** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. **Workers' Compensation.** We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease; may be at risk of contracting/spreading disease/condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION.

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

The Medical Office of The Vaz Clinic, P.A.
1103 N Sarah DeWitt Drive
Gonzales, Texas 78629
830-672-2424

To file a complaint, you may either call or send a written letter. **The Practice will not retaliate against any individual who files a complaint.**

You may also file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services.

Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)
_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records
(Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information
(Including HIV/AIDS Test Results)

_____ Genetic Information
(Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)
□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: _____

_____ _____
Patient Name Patient's Date of Birth

THE VAZ CLINIC, PA.
URGENT CARE
TVC CLINICAL RESEARCH

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830-672 -2424
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Veteran Owned and Oparated
Garth O. Vaz, M.D.

The individual signing this form agrees and acknowledges as follows:

1) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

2) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

3) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4) **Special Information:** This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

5) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, Relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

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Acknowledgement of Receipt of the Notice of Privacy Practice

Your name and signature on this document indicate that you have been given the opportunity to review and request a copy of the Notice of Privacy Practices for The Medical Office of The Vaz Clinic, P.A. on the date indicated. Additionally, you consent to the use and disclosure of your medical information as set forth in the Notice of Privacy Practice except as expressly stated below. If you have any questions regarding our medical office's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Patient Privacy Officer as indicated on your Notice.

May we release your health information to family member(s) or any other individual or care giver(s)?

( ) YES **( ) NO**

If yes, please list name and relationship below:

Name:	Phone:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to patient

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Patient Office Policy Acknowledgement Form

I have read and understand the Patient Office Polices of The Vaz Clinic, P.A. By signing below I acknowledge receipt and communication of these policies with me and have been made aware that failure to comply with the Patient Office Policies may result in my termination as a patient for The Vaz Clinic, P. A. and associated medical providers. I understand that The Vaz Clinic, P. A. reserves the right to modify the Patient Office Policies as necessary and I reserve the right to request a printed copy of the Patient Office Policies.

_____ _____

Patient/Legal Guardian Name (Print) Patient's Date of Birth

_____ _____

Patient/Legal Guardian Signature Date

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Medication Agreement & Refill Policy

In the course of your treatment you may be prescribed medication by our medical providers. Medications allow our providers to improve your health, but serious side effects may arise if certain of these medications are not managed properly. Our first priority is your health and safety. To this end, our medical providers have established guidelines and policies for your safety. **Our medical providers reserve the right to contact your other treating physicians and pharmacies regarding your healthcare, including medication. Below are the aforementioned polices and guidelines:**

1. I understand that medication refills will only be available during regular office hours. Prescription refills require a 48-hour notice, so we ask that you do not wait until you have run out of your medication before you contact our office.
2. I understand that medication refills WILL NOT be made after hours, on the weekends, or on holidays.
3. I understand that my medical providers have the right to refill or NOT refill medications prescribed to me by another medical provider.
4. I agree to provide detailed information about my medication when I request medication refills (I.E. medication name, dosage, name of pharmacy, etc.)
5. I understand that I may not be prescribed narcotic or habit-forming medication at my first visit.
6. I agree to follow the dosing schedule as prescribed to me by my medical provider.
7. I agree to NEVER share medications prescribed to me as a patient with any other person
8. I agree to NEVER sell, exchange, or trade my medications for any reason.
9. I understand that the safeguard and safekeeping of my medications is my responsibility. My medical provider will not be obligated or required to replace LOST OR STOLEN prescriptions or medications.
10. I agree to contact my medical provider if I experience any adverse effects or dosage problems with my prescription medications.
11. I agree and understand that I will not be allowed to receive narcotic or controlled medication prescriptions from my medical provider if I am also receiving similar medication prescriptions from another medical provider. Only after the express consent or consultation of my medical provider will this be authorized.
12. I understand narcotic or controlled medication prescriptions will NEVER be filled early.
13. I understand and agree to use only one pharmacy for my narcotic or controlled medication prescriptions.
14. I agree to keep all scheduled appointments and I understand that if I am 15 minutes late or later for my scheduled appointment time, I may have to reschedule.
15. I agree that NO medication will be given for cancelled or no-show appointments.
16. I agree to bring all my prescribed medications or provide an accurate list of current prescribed medication at each office visit.
17. I understand that I should not drive or operate heavy machinery while taking medications that may cause drowsiness or impaired cognitive function.
18. I agree and understand that abusive behavior or harassment toward the staff of The Vaz Clinic, P.A. will not be tolerated or acceptable.
19. I understand that if I forge, copy, or falsify prescriptions I will immediately be fired as a patient from The Vaz Clinic, P.A.
20. I understand that I will be dismissed as a patient if I violate the policies of this agreement.
21. I understand that The Vaz Clinic, P. A. reserves the right to REQUEST A DRUG SCREEN BY URINE IF I AM PRESCRIBED CONTROLLED SUBSTANCES. If my drug screening tests show positive for un-prescribed substances or negative for medications I have been prescribed, I understand I will be dismissed as a patient from The Vaz Clinic, P.A.

Patient Name (Printed) _____

Patient Signature and Date _____

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Chronic Pain & Narcotics

1. I understand that patients requiring long term pain management, over six (6) months, will require a referral to a pain management specialist. Certain diagnoses may be exempt for this requirement on a case by case basis.
2. I understand that if I am unwilling to see a pain management specialist when referred by my medical provider, I will only be prescribed non-narcotic pain management.
3. I understand that all patients with chronic pain must undergo testing to determine the source of the pain. Chronic pain without objective findings (positive tests) will not be prescribed narcotics.
4. I understand controlled, scheduled, and triplicate medications do not have refills and all patients who require prescription refills for these medications must be seen by a medical provider evaluation and documentation of their pain every three (3) months.
5. I understand that I will be required to present photo identification and sign before my triplicate prescription will be released to me. Triplicate prescriptions will only be released to the patient with the exception of nursing home residents.
6. I understand that Fibromyalgia will not be treated with narcotic pain medications.
7. I understand patients may be prescribed pain medications for short-term acute injuries (I.E. back sprain.) The prescribed medication will be for temporary use and will NOT be refilled.
8. I understand that scheduled and controlled medications can become highly addictive if abused, misused, or not taken as directed by my medical provider.
9. I understand that all patients currently receiving pain medication and who refuse to comply with this agreement and its policies will be weaned off narcotic pain medications.

Patient Name (Printed) _____

Patient Signature and Date _____

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Acknowledgement of Receipt of the Medication Agreement and Refill Policy

By signing this acknowledgement, I confirm that I have read, understood, and accepted all of the policies and sections in the Medication Agreement and Refill Policy. I agree to comply with the policies of this agreement and understand that failure to comply with this agreement may result in my dismissal as a patient of The Vaz Clinic, P. A.

Please note that medication will not be prescribed without the acceptance of this agreement.

_____ _____

Patient Name: (Print) Date:

_____ _____

Patient Signature: Guardian: (If applicable)

Authorization to Access Historical Prescription Information

I hereby authorize the medical providers of The Vaz Clinic, P. A. to access my historical prescription drug information.

_____ _____

Patient Signature: Date:

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TVC FINANCIAL POLICY

Medical Services Billing: If TVC is in-network with your insurance carrier(s) we will file charges directly to your insurance(s). You are responsible for payment of any allowable patient balance at time of service. If we know at the time of service that there is a possibility that a charge for tests or procedures are not paid by your insurance carrier you will be asked to sign a release form (ABN) acknowledging your responsibility for payment of these services.
ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE: This practice has a legal obligation to the insurance companies that we are contracted with to collect co-payments, co-insurance and deductibles at time of service. Patients are charged 10% of their account balance if the requested balance is not paid in full at time of service. Once a balance reaches 90 days old without payment, it may be transferred to a third party for further collections or other actions.
Payment due at time of service includes: ★

Copays- Copay amounts are usually listed on the front of your card. We also verify your insurance benefits for correct payment amounts.

Deductible and Coinsurance- If your insurance has deductibles and coinsurance for services provided, you are required to pay the estimated deductible and coinsurance.

Self-Pay Visits- You must pay a deposit in advance of $280 and pay for any additional services at check-out.

Cancellations/No Shows- If you do not call in advance of at least 24 hours prior to your appointment time, it is considered a "No Show". Patients are charged a $35.00 fee for 3 (three) "No Shows" plus $15.00 for EACH ADDITIONAL "No Show". Worker's Compensation patients will be personally responsible for this amount.

Auto Accidents- If you are an auto accident patient you will be responsible for paying the full balance the day of the visit. We will give you a summary of your charges so that you can submit to the auto-insurance company. We cannot bill insurance for this type of service.

Worker's Compensation- If you are being seen under a Workers Compensation claim you must have a completed injury form from your employer and/or have Dr. Vaz listed as the PCP for authorization, prior to being seen for your worker's compensation related visit. We cannot bill your regular insurance work-related claims.

Routine Physicals and Preventative Services-Some insurances have limitations on the dollar amount of service. You will be responsible for any owed amounts at the time of service.

DOT Physicals-We are no longer performing this service.

Indemnity Plans- We do not accept indemnity plans in which we are not in network. For those indemnity plans we are in-network, we require that you pay the full balance the day of the visit.
HRA/HAS Accounts- We expect payment at the time of service. We cannot wait for a HRA/HSA account to pay on claims as they do not guarantee payment. We will reimburse you, or apply the credit to your account, for any amounts paid by your HRA/HSA after you already paid at the time of service.

Patients in Third Party Collections- Patients with unpaid balances in third party collections can be terminated as patients with TVC and will be required to pay the outstanding balance in full before they can be seen as active patients of TVC.

- Patients are charged a $35 collection fee if their account balance qualifies for third party collections.

Non-Sufficient Funds- Patients are charged a $35 fee if their payment processes as non-sufficient funds.

Child Visits- A parent or legal guardian must accompany minor patients on all office visits. This accompanying adult is responsible for payment on the account.

_____Patient Initials (acknowledging)

Charges in Advance-

You are welcome to ask about our fees before the visit, but many fees are determined by the complexity of the patient's problem and the amount of time spent with the doctor. Therefore, we may not be able to state the exact amount of charges in advance. In addition to the "up-front" fees there may be a balanced owed, which you will pay at the time of check out. In the event that there is an over-collection we can apply the credit to your account or issue a refund.

AFTER HOURS FEES and OUTSIDE OF REGULAR WORKING HOURS FEES

The following fees will be asked to be paid upfront.

- Self-pay patients are charged $30.00
- Patients with insurance are charged an amount depended from the insurance carrier
- Patients with Medicare or Medicaid have no charge per insurance

The Vaz Clinic Hours
8am-12pm Mon.-Fri.
1pm-5pm Mon.-Fri.

Vaz Urgent Care Clinic Hours
8am-8pm Mon.-Fri.

I have read, understand and agree to the above Financial Policy.

I hereby assign TVC the right to bill and receive payment from my health insurances and third-party payers. I authorize TVC to release healthcare information to the necessary parties to obtain payment from my health insurance company for my healthcare, to conduct utilization review, peer review and quality assurance and to other healthcare providers that will assist with my care.

_____ _____ _____
Printed Patient Name Patient/Guardian Signature Date