

Texas Tech University Health Sciences Center Ambulatory Clinics	Patient Label (Name, DOB, MRN)
Consent to Treatment/Health Care Agreement	

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.

ADVANCE DIRECTIVE:

Do you have a current, signed Advance Directive? ___YES ___NO
Has a signed copy been provided to TTUHSC? ___YES ___NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date Print Name Signature Patient/ legally authorized person

Witness/Translator Relationship to Patient

**TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
PSYCHIATRY OUTPATIENT CLINIC/SWIAD**

CONFIDENTIALITY AGREEMENT

Confidentiality is an essential part of our treatment philosophy. We, therefore, ask you to sign an agreement that you will adhere to our confidentiality policy by not disclosing any information about any patient or other visitors that you may see/meet in the clinic.

I, _____, **HEREBY
AGREE TO ABIDE BY THE CONFIDENTIALITY POLICY OF THE
PSYCHIATRY OUTPATIENT CLINIC.**

Patient's Signature

Date

Parent's Signature (if minor)

Witness Signature

**Texas Tech University
Health Sciences Center**

Confidential Communication Request

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

- Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date _____

Print Your Name and Relationship to Patient
(Person signing consent form)

Signature
(Patient or Other Legally Authorized Person)

Relationship to Patient



Texas Tech University Health Sciences Center Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications	Patient Name: _____ MRN: _____ DOB: _____
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I have received a copy of the Texas Tech University Health Sciences Center (TTUHSC) Notice of Privacy Practices (rev. 3/16) in accordance with 45 CFR § 164.520.

Consent to Email or Text Usage for Appointment Reminders and other Healthcare Communications:

I consent to receive email and/or text messaging from TTUHSC to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general health reminders or information about new services.

The cell phone number and/or email I authorize for TTUHSC to use are listed below:

Email: _____

Cell phone number: _____

TTUHSC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

By signing below, I acknowledge any options selected above, will remain in effect until further written notification by me.

Date	Print Your Name (Person signing consent form)	Signature (Patient or Other Legally Authorized Person)
		Relationship to Patient

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
 - **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
 - **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
 - **Ask us to limit what we use and share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
 - **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
 - **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
 - **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
 - **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
 - Contact the TTUHSC privacy official at the address indicated below
 - Use our confidential website at www.Ethicspoint.com
 - Contact The Office for Civil Rights:
United States Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, Texas 75202
www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
 - Share information with your family, close friends, or others involved in your care.
 - Share information in a disaster relief situation.
 - Include your information in a hospital directory
 - If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In these cases we never share your information unless you give us written permission:**
 - Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes

TTUHSC USES AND DISCLOSURES:

How do we typically use or share your health information? The following uses do **NOT** require your authorization, except where required by Texas Law.

- **Treat you.** We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **In the case of fundraising.** We may use your PHI to contact you for fundraising efforts. We must include in any fundraising material you receive a description of how you may opt out of receiving future fundraising communications.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
 - **Help with public health and safety issues.**
 - We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
 - **Conducting Research.** We can use or share your information for health research.
 - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
 - **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
 - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
 - **Address workers' compensation, law enforcement, and other government request.**
 - We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
 - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

TTUHSC RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGE IN NOTICE OF PRIVACY PRACTICES:

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhs.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

REGIONAL PRIVACY OFFICER AT AMARILLO 1400 COULIER ROAD AMARILLO, TX 79106 (806) 414-9607	REGIONAL PRIVACY OFFICER AT LUBBOCK 3601 4TH STREET, STOP 8165 LUBBOCK, TX 79430 (806) 743-9541	REGIONAL PRIVACY OFFICER AT THE PERMIAN BASIN 800 WEST 4TH STREET ODESSA, TX 79763 (806) 743-9539
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www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.

**Texas Tech University Health Sciences Center
Patient Request for Access and/or Release of Health Information**

Patient Name: _____
MRN: _____
DOB: _____

DO NOT USE THIS FORM WHEN REQUESTING PSYCHOTHERAPY NOTES.

If you would like a copy of your medical record, please complete the form below.

Patient Name _____ Date of Birth: _____
Street Address _____ Last 4 numbers of SSN: _____
City, State, Zip: _____ Telephone: _____
Email address: _____

I would like for Texas Tech University Health Sciences Center (TTUHSC) to (choose one):

- Give me a copy of my health information
 Send my records to: _____
 Release verbal information to:
 Receive information from: _____

(Name of Facility, Person, Company) (Street address or PO Box, City, State, Zip Code)

(Phone Number) (Fax Number)

(Email Address)

I would like these dates of service to be released: _____

I want these parts of my record:

- Any and All records (complete record)

Only record types checked below:

- Progress Notes/clinic notes
 Laboratory Reports
 Immunization Record
 Medication Record
 Schedule
 Other (please specify) BSU DX - Billing
 Billing Records (dates)
 Routine Record Set (Indicate date(s) of service _____
(office visits, lab, radiology, medicines, immunizations)

I agree that the following information may be released/used only as indicated below:

- | | |
|---------------------------------------------------------------------------------|------------------------------------------------|
| 1. Aids/HIV test results, diagnosis, treatment, and related information | Yes ___ No ___ |
| 2. Drug screen results and information about drug and alcohol use and treatment | Yes ___ No ___ |
| 3. Mental health information | Yes <input checked="" type="checkbox"/> No ___ |
| 4. Genetic testing | Yes ___ No ___ |

I want these records as a (choose one):

- CD
 Electronic
 Paper copy
 Other: _____

I want you to (choose one):

- Mail them
 Send them secure email
 Send them personal email (unsecure)
 Fax them to: _____
 Prepare them to be picked up by: _____

If you request your medical record to be sent to you unencrypted via your personal email, you acknowledge and accept the risk that your PHI is being transmitted through an unsecure means of communication.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this document for the patient (Written Proof may be required)

To be completed by TTUHSC:

Date of release: _____ via Mail Fax Other _____

ID Verified DL/Other ID _____

Employee Name: _____ Date: _____



Texas Tech Physicians

Telemedicine Consent

Pt. Name: _____
Address: _____
City State Zip
MRN: _____
DOB: _____
SEX: _____
DOS: _____

I. Introduction. Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

II. Consent for Treatment. I voluntarily request Texas Tech Physicians and such associates, residents, technical assistants and other health care providers as they may deem necessary, including providers from University Medical Center (UMC), ("Texas Tech Physicians/UMC Telemedicine Providers") to participate in my medical care through the use of telemedicine.

I understand that Texas Tech Physicians/UMC Telemedicine Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that Texas Tech Physicians/UMC Telemedicine Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If Texas Tech Physicians/UMC Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

III. Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to Texas Tech Physicians/UMC Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information; 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to Texas Tech Physicians/UMC Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

Signature of Patient/Responsible Party (Relationship to Patient)

Time

Date

Signature of Interpreter/Provider Using Telephone Translation Services

Time

Date

Patient Label:	
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Patient Review of Systems

Thank you for choosing Texas Tech Physicians of Lubbock, Department of Psychiatry to be your healthcare provider. Please take a moment to complete prior to your appointment with your healthcare provider. Please circle any of the following symptoms below.

Who is your current primary care provider: _____

When was your last appointment: _____

Constitutional: fever, chills, sweats, weakness

Eye: recent visual problems, Icterus, discharge+, blurring, double vision, visual disturbances

ENMT: ear pain, sore throat, congestion, hoarseness.

Skin: jaundice, rash, lesions, petechiae

Respiratory: shortness of breath, cough, orthopnea, wheezing

Cardiovascular: chest pain, palpitations, edema

Gastrointestinal: nausea, vomiting, diarrhea, GI bleeding

Genitourinary: dysuria, hematuria, discharge, pain

Hema/Lymph: bruising tendency, bleeding tendency, swollen lymph glands

Immunologic: immunocompromised, recurrent fevers, recurrent infections, malaise

Musculoskeletal: back pain, trauma

Integumentary: rash, pruritus, abrasions, breakdown, burns, dryness, petechiae, skin lesion

Neurologic: headache, dizziness, numbness, weakness

Psychiatric: sleeping problems, irritability, mood swings/depression

Allergy/Immunologic: seasonal allergies, food allergies, recurrent infections, impaired immunity

Notes:
