

TTUHSC School of Medicine Department of Surgery Lubbock, TX Patient History Form Page 1 of 2	Patient Name: _____ MRN: _____ DOB: _____
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1. Who is your primary care Physician? _____ 2. Who referred you to our physician? _____
 Address and phone: _____

Chief Complaint

What is the main reason for your visit today?

History of Present Illness

Please answer the following questions.

When did you first notice the problem?
 2 days ago 2 weeks ago 1 month ago
 Other _____

Is the problem constant or variable?
 Dull then sharp Very sharp then leaves Always there
 Other _____

How long does the problem last?
 30 minutes 1 hour It is always there
 Other _____

Does the problem interfere with your normal functions?
 Yes No If yes, then explain _____

Past Medical History

1. List any past surgeries and/or past serious illnesses. List the dates they occurred.

2. Do you have any allergies? (If so, please list.)

3. List any serious illnesses in your family: (example—diabetes, high blood pressure, cancer)

4. List any medications, supplements, or vitamins you are taking.

Personal Medical History – Patient to fill out

	YES	NO		YES	NO		YES	NO
High Blood Pressure	___	___	Stroke	___	___	Rectal Bleeding	___	___
Thyroid trouble	___	___	Heart failure	___	___	Hernias	___	___
Epilepsy	___	___	Chest pain	___	___	Arthritis	___	___
Severe Headaches	___	___	Palpitations	___	___	Back injuries	___	___
Prolonged Dizziness/Fainting	___	___	Bleeding disorder	___	___	Broken bones	___	___
Rheumatic Fever	___	___	Tuberculosis	___	___	Other severe injuries	___	___
Vision problems/both eyes	___	___	Colitis/Irritable colon	___	___	Off work due to injuries	___	___
Hearing problems	___	___	Diverticula of colon	___	___	Mental Disorder	___	___
Mouth or throat problems	___	___	Hemorrhoids	___	___	Tumors or cancer	___	___
Persistent hoarseness	___	___	Gout	___	___	Diabetes	___	___
Shortness of breath	___	___	Ulcers/stomach problems	___	___	Unexpected weight gain/loss	___	___
Asthma	___	___	Kidney disease	___	___	Alcoholism	___	___
Emphysema	___	___	Severe bladder problems	___	___	Glasses/contacts	___	___
Heart problems	___	___						

Personal Social History

Smoke YES NO How much/how long? _____ / _____
 Alcohol ___ ___ _____ / _____

TTUHSC School of Medicine Department of Surgery Lubbock, TX Patient History Form Page 2 of 2	Patient Name: _____ MRN: _____ DOB: _____
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Review of Systems (ROS)

Please circle Yes or No if you have any of the following problems

<input type="checkbox"/> Health Good general health Yes No Recent weight changes Yes No Night sweats, fever Yes No Fatigue Yes No	<input type="checkbox"/> Ears/Nose/Mouth/Throat Hearing loss or ringing Yes No Sinus problem Yes No Nose bleeds Yes No Sore throat/voice change Yes No	<input type="checkbox"/> Eyes Wear glasses Yes No Blurred/double vision Yes No Eye disease or injury Yes No Glaucoma Yes No
<input type="checkbox"/> Heart/Vascular Chest pain Yes No Palpitations Yes No Heart trouble Yes No Swelling hands/feet Yes No	<input type="checkbox"/> Respiratory/Lung Shortness of Breath Yes No Cough Yes No Wheezing/Asthma Yes No Coughing up Blood Yes No	<input type="checkbox"/> Stomach/Colon Nausea/vomiting Yes No Abdominal pain Yes No Rectal bleeding Yes No Bowel problems Yes No
<input type="checkbox"/> Musculoskeletal Muscle pain or cramps Yes No Stiffness/swelling joints Yes No Joint pain Yes No Trouble walking Yes No	<input type="checkbox"/> Brain Function Frequent Headaches Yes No Paralysis or tremors Yes No Convulsions/seizures Yes No Numbness Yes No	<input type="checkbox"/> Skin/Breasts Change in hair/nails Yes No Rashes or itching Yes No Breast lump Yes No Breast pain or discharge Yes No
<input type="checkbox"/> Thyroid Excessive thirst/urination Yes No Thyroid disease Yes No Hormone trouble Yes No	<input type="checkbox"/> Blood Disorders/Gland Bruise easily Yes No Slow to heal Yes No Enlarged glands Yes No	<input type="checkbox"/> Allergies Food allergies Yes No Aspiring allergies Yes No Antibiotic allergies Yes No
<input type="checkbox"/> Genitourinary Blood in urine Yes No Kidney stones Yes No Sexual problems Yes No Testicle pain Yes No	<input type="checkbox"/> Genitourinary-female only Blood in urine Yes No Kidney stones Yes No Sexual problems Yes No	<input type="checkbox"/> Emotional/Mental Status Insomnia Yes No Confusion/memory loss Yes No Depression Yes No

Patient Statement: To the best of my knowledge, the above information is accurate and complete.
Signed _____ Date: _____

Notes: Physician Statement: I have reviewed the questionnaire with the patient.
Signed _____ Date: _____

For Office Use Only: **To determine the history level, draw a line down the column with circle farthest to the left **				
Chief Complaint/ Hx of Present Illness Past, Family & Social History Review of Systems	Brief (1-3 elements) None None	Brief (1-3 elements) None Problems Pertinent (1 system)	Extended (4+) 1 or 2 Hx areas Extended (2-9 systems)	Extended (4+) Three Hx areas Complete (10+ systems)
Type of History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

**Texas Tech University Health Sciences Center
Ambulatory Clinics**

**University Medical Center
Hospital**

Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by TTUHSC/UMC physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that TTUHSC/UMC is a teaching institution and I agree to be a part of the teaching programs. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the TTUHSC Ambulatory Clinics/UMC unless revoked by me in writing with such written notice provided to each clinic attended by me.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION: Your protected health information pertains to your diagnosis and/or treatment at TTUHSC/UMC, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to TTUHSC/UMC's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Privacy Practices provides information about how TTUHSC and its workforce may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

RELEASE FROM LIABILITY: I release and agree to hold harmless TTUHSC/UMC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand TTUHSC/UMC cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign 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 to TTUHSC/UMC physicians and/or Medical Practice Income Plan. 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/UMC 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/UMC.

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

ADVANCE DIRECTIVE:

I have signed an Advance Directive. YES NO;

If yes, is it still in effect? YES NO; I have provided a signed copy to TTUHSC. YES NO

NOTICE OF PRIVACY PRACTICES:

I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____
(Patient's Initials)

Date Time Patient/Other legally authorized person

Witness* Print Name Print name and relationship to patient

**Texas Tech Health Sciences Center
School of Medicine
Financial Agreement**

Patient Name: _____
MR# _____
DOB: _____

We are committed to providing you with the best possible medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, Mastercard, and Discover.
2. Our office participates with a variety of insurance plans. It is your responsibility to:
 - a. Bring your insurance card at every visit.
 - b. Be prepared to pay your co-payment at each visit. Payment can be made by cash, check, or credit card.
 - c. For medical care not covered under your insurance, payment in full is due at the time of the visit.
3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service.
4. If you are unable to pay for necessary medical care, you may be eligible for financial assistance. You will be required to go to the Texas Tech Health Sciences Center Financial Screening Department before your next appointment, to determine if you are eligible for medical assistance.
5. Referrals: It is your responsibility to bring any required referral-certification/authorization for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you may be financially responsible.
6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service; bringing the necessary referral certification/authorization; and bringing his/her insurance card.
7. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (telephone number is on the insurance card).
8. If you fail to make payment in full for the services that are rendered, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, we may choose to cease providing services to you.

Texas Tech University Health Sciences Center firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangement should be asked prior the receipt of services.

Please sign below to indicate you have read, and agree to, this Financial Policy.

Signature of Patient or Responsible Party

Date

Signature of Co-Responsible Party

Date

Texas Tech University Health Sciences Center Confidential Communication Request Form	Patient Name: _____ MRN: _____ DOB: _____
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Patient Contact information:

Street Address _____

City, State, ZIP _____

Phone number _____

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. TTUHSC may condition the reasonable accommodation regarding information as to how payment, if any, will be handled and specification of an alternative address or other method of contact. TTUHSC does not require an explanation as to the basis for the request as a condition of providing confidential communications.

Although TTUHSC cannot leave specific test results on answering machines due to our concern for your privacy, we are willing to communicate with you as you specify: (or direct)

Permission to give protected health information or leave messages with the following person or persons:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Permission to call the following numbers to leave messages (without disclosing protected health information) :

Location: _____ Phone #: _____

Location: _____ Phone #: _____

Location: _____ Phone #: _____

Please note any additional special accommodations needed:

Date

Time

Patient/Other legally authorized person

Witness

Print Name

Print name and relationship to patient

Limited data set-We may use and disclose limited PHI that does not fully identify you only for purposes of research, public health, or health care operations.

Parental access- To your parents or legal guardian if you are under the age of 18, unless it is prohibited by Texas law. Other than the categories mentioned above, TTUHSC will not disclose your PHI without your written authorization. You may revoke your written authorization at any time in writing; however, your written revocation will only apply to PHI that has not already been used or disclosed by TTUHSC under your written authorization.

YOUR PRIVACY RIGHTS

Right to inspect and copy-You have the right to inspect and request a copy of your PHI that is in a designated record set. This includes your insurance and billing records but not counseling notes of a mental health professional, information prepared by or for our attorneys to defend TTUHSC, or where prohibited by law. You may be charged a reasonable fee to obtain a copy of your PHI. TTUHSC reserves the right to deny your request to access or receive a copy of your PHI as provided by law. All requests must be in writing using the TTUHSC authorization for release of patient information form.

Right to request restrictions- You have the right to request TTUHSC limit its use or disclosure of your PHI for treatment, payment, or health care operations. You may also request that TTUHSC limit its disclosure of your PHI to family members, relatives, close personal friends or others you have identified as being involved in your care. We are not required to agree to your request. If we agree to your request, we will limit use or disclosure of your PHI except in certain cases, including where the information is needed to treat you or to verify coverage in the case of an emergency. To request restrictions, you must make your written request to a TTUHSC privacy official. Your request must include: 1) the information that you want to limit, 2) how you want to limit the information, and 3) to whom you want those limitations to apply.

Right to request confidential communication- You have the right to request other means or locations to receive communications about your PHI. All requests must be in writing using a TTUHSC confidential communication request form. TTUHSC will agree to readable requests for other means or locations to receive communications about your PHI.

Right to request a change in your PHI-You have the right to request TTUHSC change information in your PHI for as long as TTUHSC keeps your PHI. TTUHSC can deny your request to change your PHI as provided by law. All requests must be in writing using a TTUHSC

Amendment request form.

Right to an accounting of disclosures- You have the right to request an accounting of certain uses and disclosures of your PHI by TTUHSC. This is a use of disclosures made by TTUHSC during the past six years; except for uses or disclosures made:

- For treatment, payment, and health care operations;
- To family members or friends involved in your care;
- To you directly;
- Pursuant to a written authorization;
- For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); or
- Before April 14, 2003

If you wish to make a request for an accounting contact the privacy official to obtain a TTUHSC accounting request form. The first list of accounting that you request in a 12-month period will be free, but we may charge you for any additional ones requested during the same 12-month period. We will tell you about these costs, and you may cancel your request at any time before costs are incurred.

Right to a paper copy of this notice-You have the right to receive a paper copy of this notice of privacy practices upon request. Even if you have agreed to receive this notice electronically, you can still receive a paper copy of this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint in one of the following ways:

- The TTUHSC privacy official at the address indicated below
- Call our confidential Toll Free number at 1-866-294-9352
- Use our confidential website at www.Ethicspoint.com
- The Office of Civil Rights:
United States Dept. Of Health and Human Services
1301 Young Street, suite 1169
Dallas, Texas 75202

We will not retaliate or take action against you for filing a complaint.

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.ttuhsu.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION
SHAUNA BAUGHUM
TTUHSC INSTITUTIONAL PRIVACY OFFICER
3601 4TH STREET, MS 8165•LUBBOCK, TX 79430
(806) 743-4007
www.Ethicspoint.com



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

NOTICE OF PRIVACY PRACTICES

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

Effective: April 14, 2003
Revised: January 1, 2008

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.

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, primary care specialty clinics, 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. This notice also tells you about your privacy rights and TTUHSC's legal duties with respect to your PHI. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

CHANGE IN NOTICE OF PRIVACY PRACTICES: TTUHSC reserves the right to change this notice of privacy practices at any time. Any changes will apply to all PHI that TTUHSC created or maintained for you. If this notice is changed, it will be posted at our clinics and on our website (www.ttuhscc.edu/hipaa) and you can request a copy of this notice.

TTUHSC PERMITTED USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION:

TTUHSC may use or disclose your PHI without your written authorization for the following:

TREATMENT: Your PHI may be used and disclosed to provide, coordinate or manage your health care and related services. This may include talking with other health care providers about your treatment or coordinating and managing your health care with others. *For example, when your family physician refers you to another doctor your family physician may tell the other doctor about any drug allergies you may have so the other doctor can diagnose or treat you.*

PAYMENT: Your PHI may be used and disclosed to obtain payment for your health care services. *For example, TTUHSC may share your PHI with your health insurance plan for payment of health care items or services provide to you.*

HEALTH CARE OPERATIONS: Your PHI may be used and disclosed to support our business activities. These includes, but are not limited to, quality evaluation, work force reviews, education and training of students and physicians in training, licensing, fundraising, and conducting or arranging for other business

activities. *For example, TTUHSC may use your PHI to evaluate the performance of our staff in caring for you.*

OTHER USES AND DISCLOSURES : OPPORTUNITY FOR YOU TO AGREE OR OBJECT: *TTUHSC may use or disclose your PHI without your authorization for the following purposes unless you object:*

Involvement in patient care and notification purpose -To a family member, other relative, close personal friend or other person you have identified as involved with your treatment or payment for health care services. We may also use your PHI to notify or assist in notifying such persons of your location or health.

Disaster relief efforts- To public or private relief agencies to assist in disaster relief efforts.

Appointment reminders-We may contact you to remind you of your health care appointments or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fundraising- Limited PHI about you to a business associate or foundation related to TTUHSC to raise funds for TTUHSC. Fundraising materials will contain information on how you can refuse to receive any further fundraising materials for TTUHSC.

USES AND DISCLOSURES OF PHI WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT
TTUHSC may be allowed or required to use or disclose your PHI without your authorization or opportunity for you to agree or object for the following reasons:

Required or authorized by law- As required by federal, state, or local law. Any disclosure must comply with the law and is limited to the requirements of the law.

Public health activities-To public health authorities or other authorized persons to carry out certain public health activities, including the following:

- To report, prevent, or control disease, injury or disability;
- To report vital statistics, such as birth or death;
- To report child abuse or neglect;
- To report bad reactions to medications or problems with products or devices regulated by the food and drug administration;
- To locate and notify you of recalls or products you may be using;
- To notify a person who may have been exposed to a contagious disease in order to control who may be at risk of contracting or spreading the disease; or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, neglect, or domestic violence- In certain cases to proper government authorities if we have reason to believe that you have been the victim of domestic violence, abuse, or neglect.

Health oversight activities- To a health oversight agency for over-

sight activities authorized by law such as audits, investigations, inspections, and licensure activities or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial, administrative and law enforcement purposes-Where requested by law enforcement, and as authorized or required by law, we may disclose your PHI:

- In response to a court order, subpoena, warrant, summons or similar process;
- In response to requests for limited information necessary to identify or locate a suspect, fugitive, material witness, or missing person;
- If we suspect that you are a victim of a crime and if you agree to the disclosure, or under certain circumstances, where we are unable to obtain your permission;
- About your death if we suspect it is the result of criminal conduct;
- About criminal conduct that occurs at TTUHSC; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Decedents- To a coroner or a medical examiner to identify you and determine the cause of your death in addition, we may disclose your PHI to funeral directors, as authorized by law, so that they may do their jobs.

Organizations that obtain organs-If you are an organ donor, after your death we may use or disclose your PHI to organizations that help get, locate, store, and transplant organs to help with organ, eye, or tissue donation and transplantation.

Research- For research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA privacy rule.

To stop a serious threat to health or safety- In limited circumstances when necessary to help stop a threat to the health or safety of a person or to the public. This disclosure can be made only to a person who is able to help stop the threat.

National Security, Intelligence Activities, and Protective Services-To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

Correctional institutions-Of inmates or other individuals under lawful custody to a correctional institution or law enforcement officer for the provision of health care, health and safety matters, law enforcement purposes or security of the correctional institution.

Worker's compensation- To comply with workers' compensation programs or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

Continued