Texas Tech Physicians of LUBBOCK SURGERY

Patient Name: _____

MRN: _____

DOB: _____

Patient History Form

1. Who is your primary care physician?_____ 2. Who referred you to our physician?_____

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

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

Occupation _____

Patient History Form

Review of Systems (ROS)

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

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

Confidential Communication Request
And
Identity Theft Protection Questions

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 or 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.**

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

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

Phone #: _____ Phone #: _____

☐ Permission to use e-mail address for the purpose of providing information about on-line patient portal and general information about TTUHSC.

E-mail address: _____

Security and Identity Theft Protection Questions: Please provide a minimum of two answers.

1. What was the name of the elementary school you attended? _____
2. What is your mother's maiden name? _____
3. What model was your first car? _____
4. What town were you born in? _____

Date	Print Name	Signature (Patient or Other Legally Authorized Person)
Time	Witness/Translator	Relationship to Patient

Texas Tech University Health Sciences Center
Ambulatory Clinics

Consent to Treatment/Health Care Agreement

Patient Label (Name, DOB, MRN)

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 care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment 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 acknowledge that TTUHSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

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 acknowledge that "protected health information" pertains to my diagnosis and/or treatment at TTUHSC 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, prescriptions, medical history, prescription history, treatment progress or any other such related information.

I acknowledge that the "Notice of Privacy Practices" provides information about how TTUHSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

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:

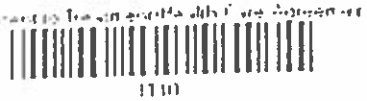
Has an Advance Directive been signed?	___ YES	___ NO
If yes, is it still in effect?	___ YES	___ NO
Has a signed copy been provided to TTUHSC?	___ YES	___ NO

NOTICE OF PRIVACY PRACTICES:
I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

I certify that I have read this form or it has been read to me*.

Date _____ Print Name _____ Patient/Other legally authorized person _____

Time _____ Witness/Translator* _____ Relationship to Patient _____



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Revised May 2012
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TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: SEPTEMBER 23, 2013

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
  - Contact you for fundraising efforts, but you can tell us not to contact you again.
  - 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? We typically use or share your health information in the following ways.

- **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.
- **How else can we use or share your health information?** We are allowed or required to share you 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.ttuhsc.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

SONYA CASTRO
INSTITUTIONAL PRIVACY OFFICER
3601 4TH STREET, STOP 8165
LUBBOCK, TX 79430
(806) 743-3949

ALICIA KRIZAN
REGIONAL PRIVACY OFFICER
AMARILLO
1400 COULTER RD, ROOM B903
AMARILLO, TX 79106
(806) 354-5588

YVETTE QUINTANA-CHAVEZ
REGIONAL PRIVACY OFFICER
EL PASO
4800 ALBERTA AVENUE
EL PASO, TX 79905
(915) 215-4456

MELISSA CASTRACANE
REGIONAL PRIVACY OFFICER
AT THE PERMIAN BASIN
800 WEST 4TH STREET
ODESSA, TX 79763
(432) 703-5160

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.