TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Department of Pediatrics

Effective Immediately

ALL MEDICAID/CHIP PATIENTS & HMO POLICIES

ALL PATIENTS OF THIS CLINIC MUST HAVE ONE OF OUR DOCOTORS INDICATED AS THE PRIMARY DOCOTOR ON THEIR POLICY SO THAT DOCOTRS AND NURSING STAFF CAN PROVIDE ADEQUATE CARE TO YOUR CHILD. WHILE YOU ARE WAITING TO BE CALLED BACK, PLEASE MAKE SURE ONE OF THE FOLLOWING DOCTORS IS LISTED AS THE PCP. IF NOT, PLEASE CALL NOW. THIS CAN CAUSE ISSUES WITH BILLING AND REFERRALS.

- **DR BABATUNDE JINADU NPI#: 1194854836**
- **DR STEPHANIE VILLARREAL NPI#: 1023456407**
- **CHRISTY GARNSEY, NP IS UNDER DR JINADU AND CANNOT BE LISTED ON THE POLICY**
- **MELISSA MARTINEZ, NP IS UNDER DR JINADU AND CANNOT BE LISTED ON THE POLICY**

PLEASE ENSURE WHEN PROVIDER IS SELECTED THAT THE ADDRESS ASSOCIATED IS THE FOLLOWING:

701 W 5TH ST.

ODESSA, TX 79763

BE AWARE THAT IF YOUR CHILD NEEDS A REFERRAL TO SEE A SPECIALIST OR ANY KIND OF MEDICAL SUPPLIES/EQUIPMENT, OUR PROVIDER MUST BE INDICATED AS THE PCP. IF OUR PROVIDERS ARE NOT LISTED IT WILL CAUSE A DELAY IN CARE.

MEDICAID #'S TO CALL:

- **AMERIGROUP #: 800-600-4441**
- **SUPERIOR #: 800-783-5386**
- **CHIP #: 800-783-5386**
- **FIRSTCARE #: 800-431-7798**

HMO POLICIES PLEASE CALL NUMBER ON THE BACK OF THE CARD.

THANK YOU.

Texas Tech Physicians
of the PERMIAN BASIN

Date: _____ D#: _____

SECTION 1	PATIENT INFORMATION				
Patient Full Legal Name		Date of Birth	SSN	Sex ☐ Male ☐ Female	
Address (Number) (Street) (Apt. No.)					
City	State	Zip	Phone (Home)	Phone (Cell)	
Marital Status		Employer			
Emergency Contact Name		Relationship		Contact Phone	
Spouse		Contact Phone			

The Following Responsible Party is the "Guarantor" and is responsible for the cost of services to the Patient:					
Full Legal Name		Date of Birth	Relationship to Patient		
Address (if different than Patient)	City	State	Zip	Phone (Home)	Phone (Cell)

The following Information is regarding the Insurance cardholder if other than Patient or Responsible Party:		
Full Legal Name	Date of Birth	Social Security Number

SECTION 2:	Primary and Secondary Insurance if applicable	
Primary Insurance Name		Subscriber Name
DOB	Relationship	Policy Number
Group Number	Claims Address	
Secondary Insurance Name		Subscriber Name
DOB	Relationship	Policy Number
Group Number	Claims Address	

Texas Tech University Health Sciences Center **Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications**	Patient Name: _____ MRN: _____ DOB: _____

☐ 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	

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 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	

Revised June 2020
6.21.B

Health Information Exchange (HIE) Participation Change

UMC HEALTH SYSTEM

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Name: _____ Date of Birth: _____

Street Address: _____ Medical Record #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

University Medical Center, Texas Tech University Health Sciences Center and UMC Physicians participate in a Health Information Exchange (HIE). The HIE is a secure, electronic way of sharing health information among participating hospitals, doctors' offices, pharmacies, and other healthcare providers. An HIE is important because sharing health information improves care. The HIE helps participating providers share information in a timely manner and more effectively coordinate your care.

I wish to change my participation status in the HIE. I have selected the correct status below:

○ **I DO NOT WANT TO PARTICIPATE IN THE HIE**

After considering my option of participating in the HIE, I have decided to OPT OUT and NOT participate in the HIE. By choosing to OPT OUT of the HIE, I hereby acknowledge and agree as follows:

1. Opting out of the HIE may delay access to important medical information.
2. My health information will not be shared among healthcare providers through the HIE. Instead, my providers will continue to share my information via previously established methods, such as phone, fax, or mail.
3. My health information will NOT be shared with other HIEs in which UMC, TTUHSC, and UMCP may participate.
4. Any information that is shared before I submit this HIE Opt-Out form may remain with providers who accessed information before this Opt-Out went into effect.

○ **I WANT TO PARTICIPATE IN THE HIE**

I previously opted out of participating in the HIE, but I have changed my mind. I want my medical information to be shared with healthcare providers through the HIE.

I understand that my HIE selection above will remain in effect unless I change it in writing. I understand that this request can take up to 3-5 business days to take effect.

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting on behalf of the person named above as: (Check One)

☐ Parent ☐ Legal Guardian ☐ Other (Specify Relationship): _____

Printed Name: _____ Date: _____

Signature: _____

Please forward the completed and signed HIE Opt-Out Forms to UMC by one of the following methods:

1. Fax to: 806-775-9157
2. Mail to: University Medical Center-Health Information Management; 602 Indiana Avenue; Lubbock, TX 79415

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 **Authorization Form for Verbal Release of Protected Health Information**	**Patient Name:** _____ **MRN:** _____ **DOB:** _____

- *At the patient's request, this authorization grants permission to a Texas Tech University Health Sciences Center (TTUHSC) provider to discuss patient health information, in person or by telephone, with an individual designated by the patient. This authorization is applicable for **verbal information only** and is not valid for the release of the written medical record.*

I authorize the following TTUHSC provider:

Provider name: _____

Department/Clinic: _____

Relationship to patient (i.e. PCP, Specialist, Counselor, etc.): _____

Phone number: _____

to release the following information:

___ Medical information about care & treatment (specify if needed): _____

___ Financial and insurance information (specify if needed): _____

___ Other (specify if needed): _____

___ All information related to my care, treatment, & payment

to the following individual:

Name: _____

Relationship to patient: _____

Phone number: _____

I understand that:

- **This Authorization expires 180 days from the date signed or on the following date or event (specify) _____.**
- This authorization is voluntary and I may refuse to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.
- This Authorization may be canceled by submitting a written notice to TTUHSC (or the releasing facility). Information may be released until my written notice of cancellation is received.
- Additional information is in TTUHSC's Notice of Privacy Practice.

RELEASE FROM LIABILITY: I release and agree to hold harmless TTUHSC Clinic (or other releasing facility) and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand TTUHSC Clinic (or the releasing facility) cannot be responsible for use or rediscover of information to third parties.

⇨ **By signing this authorization, I acknowledge that I have read this form or had it read to me, and I understand the contents in this form.**

Print Name (Person signing this form): _____

Signature (Patient or Other Legally Authorized Person): _____

Relationship to Patient: _____

Phone Number: _____ Date: _____

Informed Consent to Telemedicine/Telephone/Telepharmacy/Teletherapy Consultation

You are scheduled for a telemedicine/telephone/telepharmacy/teletherapy consultation. Prior to your visit, is important that you read and understand this document.

By signing this document, you are attesting that you understand:

1. The purpose is to assess and treat your medical condition.
2. This consult is done through a two-way communication whereby the physician or other health provider at TTUHSC can see your image on the screen and/or hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touchor smell; and it may not be equal to a face-to-face visit.
3. Since we are in different locations, we must rely on information provided by you. TTUHSC and affiliated telemedicine/telephone/telepharmacy/teletherapy consultants rely on your accurate and complete information to provide appropriate care.
4. You can ask questions and seek clarification of the procedures and telemedicine technology.
5. You can ask that the telemedicine exam and/or videoconference be stopped at anytime.
6. You know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed, heard or videotaped by medical and non-medical persons for evaluation, informational, research, educational, quality, technical purposes, or as might be required by my health coverage plan.
8. You understand you can make a complaint of your provider to the appropriate licensing board.

If you have any questions or concerns about this document, please make sure to ask your nurse or healthcare provider.

Printed Name: _____

Signature: _____

Date: _____

Revised March 17, 2020

Texas Tech Physicians
of the PERMIAN BASIN

AUTHORIZED CONSENT INFORMATION

List two individuals, other than parents/guardians, who are authorized to give consent for medical treatment for child. Please update list as soon as possible if any changes are needed.

Patients Name: _____

Patients Date of Birth: _____

Name: _____

Relationship to Child: _____

Driver's License #: _____ Phone: (_____) _____

Name: _____

Relationship to Child: _____

Driver's License #: _____ Phone: (_____) _____

Parent/Guardian Signature: _____

Date: _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ Male ☐ Female

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Medical Records
701 W. 5th Street, Room 1243
Odessa, Texas 79763 Telephone
432-703-5440

Texas Tech University Health Sciences Center **Patient Request for Access of Health Information**	Patient Name: _____ MRN: _____ DOB: _____

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: ☐ Receive the 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: _____

Information to be released:

☑ 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) _____
☐ 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 ✓ No ____
4. Generic testing — Yes ✓ No ____

I want these records as a (chose one):

☐ CD-encrypted – password_____ ☐ CD-unencrypted
☐ USB –encrypted – password _____ ☐ USB-unencrypted
☐ Electronic
☐ Paper copy
☐ Other: _____

I want you to (choose one):

☐ Mail them
☐ Send via email (encrypted)
☐ Send via email (unencrypted)
☐ 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 mail, you acknowledge 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: _____