TEXAS A&M UNIVERSITY
School of Nursing

Texas A&M School of Nursing
Nursing Mobile Clinic
(979) 436-0587
NursingMobileClinic@tamu.edu

8441 Riverside Parkway
MS - 1359 TAMU
Bryan, TX 77807

PATIENT INFORMATION FORM

Patient Information		
First Name:	**Middle Initial:**	**Last Name:**
Previous Name, if applicable:		
Date of Birth:	**SSN:**	
Gender: ○ Male ○ Female ○ Unknown		
Marital Status: ○ Single ○ Married ○ Partner ○ Divorced ○ Widowed ○ Legally Separated		
Address:		
City:	**State:**	**Zip Code:**
County:		
Phone:	**Type:**	**Leave Message?** ☐ Yes ☐ No
E-mail:		
Alternate Phone:	**Type:**	**Leave Message?** ☐ Yes ☐ No
Alternate E-mail:		
Preferred Language:		
Preferred Contact Method:		

Referring Provider	
Referring Provider:	**Referring Provider Phone:**
Preferred Pharmacy:	**Preferred Pharmacy Phone:**
Allergies:	

Minor Patients *Please complete this section if you are registering someone under 18.*	
Guardian	
Name:	
Address:	
Phone:	**Leave Message?** ☐ Yes ☐ No
Guardian	
Name:	
Address:	
Phone:	**Leave Message?** ☐ Yes ☐ No
Other Contact	
Name:	**Relationship to Patient:**
Address:	
Phone:	**Leave Message?** ☐ Yes ☐ No

Additional Emergency Contact (not self/parent)	
Name:	**Relationship to Patient:**
Address:	
Phone:	**Leave Message?** ○ Yes ○ No

Patient Information		
Does Patient have Insurance?	○ Yes ◉ No	**Insurance Company:**
Policy Holder's Name: (As written on card)		**Subscriber's ID#:**
Group #:		**Insurance Company Phone:**
if Policy Holder is different than patient		
Policy Holder's SSN:	**Date of Birth:**	**Relationship to Patient:**

Qualify for Affordable Care

*Please fill out this section if you have **no insurance** or prefer to **pay cash** for services.*

Guarantor Employment Details		
Pay Rate:	**Hourly:**	**Bi-Weekly Income:**
Family Size:	**Number of Adults:**	**Number of Dependents:**
Spouse Employment Details:		

Federal Demographic Information

To comply with Federal Regulations, we have been directed to collect information from our patients on their race and ethnicity. Please select from the following Federally approved choices:

Race:

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Do Not Wish to Specify

Ethnicity:

- ○ Hispanic/Latino
- ○ Non-Hispanic/Latino
- ○ Do Not Wish to Specify

Preferred Language:

- ◉ English
- ○ Spanish
- ○ Other: _____

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MEDICAL TREATMENT CONSENT AND FINANCIAL AGREEMENT

I,_____, *(if minor, for)* _____

hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by Texas A&M Health or their authorized designees, as they may, in their professional judgment, deem necessary to provide appropriate medical care.

All medical fees are due at the time of your appointment unless other arrangements have been approved.

- Services are rendered to the patient, not the insurance company. Our office will file your insurance if proper information is received.
    - You are responsible for co-pays, deductibles, non-covered services, co-insurance, and items considered "not medically necessary" by your insurance.
    - For unpaid claims over 45-days, it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
- It is your responsibility to notify the office of any changes in your insurance or demographics.
- You will be responsible for any charges that occur if changes to your current insurance are not communicated at the time of service.
- Expenses occurred to collect patient-responsible debt may be charged to the patient or guarantor.

By signing,

- I authorize Texas A&M Health to submit bills to my insurance company for services provided by my medicalproviders.
- I authorize the release of information of the patient's necessary medical information to process claims associated with medical care.
- I authorize payment to be made to Texas A&M Health for services provided by them.
- I have received and/or accept the following agreements and/or policies:
    - Notice of Privacy
    - Office Policies
    - Authorization to Release Medical Information to Personal Representative
    - Consent Agreement for Telecommunications and E-mails
    - Audio/Video Recording Authorization Form
    - Medical Treatment Consent and Financial Agreement

Self

_____ _____

Signature of Patient or Legal Guardian *Relationship to Patient*

_____

Date

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OFFICE POLICIES

After Hours Care

We do not provide after-hours care. If you experience a medical emergency, please call 911 and go to the nearest emergency room.

Arriving for Your Appointment

Please bring past medical records and/or vaccination records, all current medications within their original bottles, insurance card, and photo ID to every appointment.

Patients should arrive 15-minutes before your scheduled appointment. New patients should arrive at least 30-minutes before your scheduled appointment to ensure all new patient information is complete prior to your scheduled appointment time.

Treatment of Minors

Patients under the age of 18 must be with a parent or legal guardian OR have written permission for treatment from a parent or legal guardian.

Cell Phone Usage

To provide the best care possible, we request no cell phone usage during patient visits. It is in the interest of your safety that you provide your full attention to your care team and be an active participant in your treatment plan.

Prescriptions and Refills

The best time to get a prescription refill is at your appointment. If you need a refill, please contact your pharmacy and allow 72-hours for processing. Some medications have side effects that need to be monitored. We require check-up appointments every 3-4 months for these medications. Be sure to keep these follow-up appointments. Most refills will be sent electronically. Some prescriptions cannot be called in or sent in electronically. These prescriptions must be written for you to pick up and will be processed within 72-hours. Your are required to bring a photo ID each time you pick up these prescriptions.

Controlled Substances

If you require chronic use of controlled substances, our nurse practitioners will refer you to a specialist. You may also be asked to agree to a controlled substances/pain medication contract and agree to submit to urine drug screens.

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Patient Name:_____ Patient DOB: _____

CONSENT AGREEMENT FOR TELECOMMUNICATIONS AND E-MAILS

I authorize Texas A&M Health to send text messages and/or e-mails regarding appointment reminders to me or authorized individuals on the below provided cell phone number and/or e-mail.

By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text messaging charges form my cell phone provider may apply.

Parent/Guardian's Name	
Parent/Guardian's Cell Phone	
Parent/Guardian's E-mail	
Authorized Individual's Name	
Authorized Individual's Cell Phone	
Authorized Individual's E-mail	

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18-years of age, and that I agree to all terms and conditions of the text message services. I understand that this authorization can only be revoked in writing.

Text communication is not always secure. Text messages can be intercepted, and for this reason, we do not communicate personal health information through text messaging.

Signature of Patient or Legal Guardian	
Relationship to Patient	Self
Date	

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Patient Name: _____ **DOB:** _____

ACKNOWLEDGEMENT AND CONSENT OF RECEIPT OF NOTICE OF PRIVACY

I have reviewed Texas A&M Health Science Center's Notice of Privacy. This policy explains how my medical information will be used and made known. I can get a copy of this document at no cost to me if I ask for it.

Patient requested copy: ☐ Yes ☐ No

CONSENT FOR PRESCRIPTION RECONCILIATION

I, _____, will let my doctor and/or his staff to look at my bills from my pharmacy to see what medications I have purchased.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO PERSONAL REPRESENTATIVE

I, _____, hereby authorize to have my information released to the following individuals. This authorization will remain in effect until otherwise notified by me in writing.

- ☐ Appointment times
- ☐ Billing/Demographic Information
- ☐ Medical Information
- ☐ Do NOT release any information, except to healthcare providers

_____	_____
Name	Relationship / Phone Number
_____	_____
Name	Relationship / Phone Number
_____	_____
Name	Relationship / Phone Number

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Patient Name: _____ **DOB:** _____

CONSENT FOR MY HEALTHCARE PROVIDER(S) TO VIEW MY HEALTH INFORMATION IN THE HEALTH INFORMATION EXCHANGE

This consent allows you to permit Texas A&M Health to view and access your health information through a computerized system called a Health Information Exchange. The Health Information Exchange collects information from the places where you receive medical treatment and makes it available electronically to your Provider at Texas A&M Health. Your health information is used by your Provider at Texas A&M Health for a higher quality of care and to coordinate your medical care with other healthcare providers.
If you give your consent, Texas A&M Health Providers will be able to view all your health information in the Health Information Exchange for your care.

1. When your provide consent, Health Information Exchange participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
    - Provide you with medical treatment and related services.
    - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.

2. The information about you comes from participating organizations that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories, and other health care organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of mediations your doctor has prescribed. This may include information created before the date of this CONSENT form. This information may relate to sensitive health conditions, including, but not limited to:
    - Alcohol or drug use problems
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Birth control and abortion (family planning)
    - Sexually transmitted diseases

3. Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Federal and State law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your provider.

4. Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it with Texas A&M Health.

5. You may revoke your consent at any time by signing a new consent form during the registration process. Changes to your consent status may take up to 72 hours to become active/revoked in the system.

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6. Federal and state laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the Health Information Exchange, including your medical information, is encrypted to federal standards. Texas A&M Health Notice of Privacy Practices describes how your medical information is used and protected.

7. You are entitled to receive a copy of this Consent Form after you sign it.

Texas A&M Health are current members of the following Health Information Exchanges:

- Care Quality
- Commonwell
- Greater Houston Healthconnect

INITIAL by **ONLY ONE** to indicate your consent or deny consent.

_____ **I GIVE CONSENT** for Texas A&M Health Providers to access my health information through **ALL** available Health Information Exchanges (listed above)

_____ **I DENY CONSENT** for Texas A&M Health Providers to access my health information through the Health Information Exchanges

_____ Self

Signature of Patient or Legal Guardian *Relationship to Patient*

_____

Date

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AUDIO/VIDEO RECORDING AUTHORIZATION FORM

I understand that audio/video recording may occur during my clinic visits for supervision and teaching purposes.

- I understand that the trainees are supervised by a licensed family nurse practitioner, psychologist, and/or licensed dentist during all audio/video recorded clinic visits.
- I understand that staff and trainees may view my appointment through the use of audio/visual recording for the purposes of clinical supervision and teaching.
- I understand that audio/video recordings of my clinic visits are used only for the purpose of clinical supervision and teaching.
- I understand that audio/video records of my clinic visits will comply with all HIPAA regulations and will be stored on a password protected computer.
- I understand these recordings are not part of my medical record and will be deleted annually on June 30th.

◯ **I have read (or heard a staff member read to me if unable to read), understand, and AGREE to the procedures.**

◯ **I have read (or heard a staff member read to me if unable to read), understand, and DO NOT AGREE to the procedures.**

Name of Patient _____ Date _____

Signature of Patient or Legal Guardian _____ Relationship to Patient Self

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Office at the phone number or email address listed at the bottom of this notice.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described below. We are required by law to:

- Keep medical information about you private and secure;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently ineffect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment, such as sending billing information to your insurance company or Medicare; and to support our healthcare operations, such as comparing patient data to improve treatment methods or for professional education purposes (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization is required for most disclosures other than emergencies.

Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. It is always your choice to opt out of receiving fundraising communications from us.
We may use or disclose medical information about you without your prior authorization for several other reasons, subject to certain requirements, including for public health purposes, abuse or neglect reporting, disease prevention, health oversight audits or inspections, working with coroners or medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal processes.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

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 any other situation not covered by this notice, including the use or disclosure of psychotherapy notes or the use or disclosure of medical information about you to sell such information or for marketing purposes, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Who will follow this notice?

Texas A&M Emergency Medical Services, Texas A&M School of Dentistry, Texas A&M Clinical Care Practice Plan, and Texas A&M Nurses Care Access Network (CAN) facilities provide health care to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any of the locations of our entities listed above; and
- All employees, medical staff, affiliates, trainees, students, or volunteers of our entities listed above.

While each of these facilities and affiliates operates independently, they may share your health information with each other for coordination of care, treatment, payment, and healthcare operations purposes.

Right to Be Notified of a Breach:
We will notify you promptly in the event that the confidentiality of your information has been breached.

Right to Access and or Amend Your Records:

In most cases, you have the right to look at or get an electronic or paper copy of medical information that we use to make decisions about your care. All requests for copies or access must be submitted in writing to the Medical Record or Billing Department of the respective entity, as appropriate. If your request for inspection is granted, we will arrange for a convenient time and place for you to look at your record. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement if we decide not to amend a record.

Right to an Accounting:

You have the right to request a list accounting for any disclosures of your health information we have made, who we shared it with, and why we shared it, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions as required by law.

To request this list of disclosures, indicate the relevant period which must be within the past six years. You must submit your request in writing to the Medical Record or Billing Department of the respective entity, as appropriate.

Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible.

If you pay all charges associated with the services you received out-of-pocket in full, you may request that your information is not shared with an insurer for purposes of payment or other purposes unrelated to your treatment. We will honor your request unless we are required by law to release your information to the insurer.

We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location that you want us to use to communicate with you.

Right to request a paper copy of this notice:

You may receive a paper copy of this notice from us upon request, 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.

Changes to this notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site.

You can receive a copy of the current notice at any time upon request. The effective date is listed at the end. Copies of the current notice will be available each time you come to receive treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about your records, you may contact our Privacy Office listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Texas A&M Privacy Office
privacy@tamu.edu
979-845-9853
Toll Free: 833-261-1247