NOTICE OF PRIVACY PRACTICES CONTINUED

You may have the following rights with respect to you PHI (Protected Health Information)

- The right to request restrictions on certain uses and disclosure of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to honor a restrictions request except to limited circumstances which we shall explain if you ask. IF we do agree to the restrictions, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information.
- The right to inspect and copy your PHI
- The right to have your PHI amended
- The right to receive an accounting of disclosures of our PHI
- The right to obtain a paper copy of the notices
- The right to be activated if your unprotested PHI is intentionally or unintentionally disclosed
- The right to be advised if your unprotected PHI intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full request that we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

This notice is effective as of November 30, 2017e and it is our intention to abide by the terms of those Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain.

You may file a formal complaint to the US Department of Health and Human Services for Civil Rights: 200 Independence Avenue, SW
Washington, DC 20201
1-877-696-6775
Or visiting the website at WWW.HHS.GOV/OCR/PRIVACY/HIPPA/COMPANTS
You may contact our Practice Compliance Officer at the following address and phone number: Practice Compliance Officer: Rayna Zachary

Address:	220 N. Ridgeway Dr. Cleburne, Texas 76033
Phone Number:	817-556-5800
Email Address	Rzachary@I35CPG.COM

I ACKNOWLEDGE THAT I WAS PROVIDED WITH THE NOTICE OF PRIVACY PRACTICES OF THE MEDICAL PRACTICE NAMED AT THE TOP OF THIS PAGE.

Signature of Patient:_____ **Date:**

Family Medicine Associates
CLEBURNE • JOSHUA
A member of the Veritas Physician Group

Health Information Exchange Authorization

Cleburne/Joshua Family Medicine Associates participates in health information exchanges.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law.
I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I authorize the above provider to disclose my medical information described above to the HIEs in which Grant Craig, MD & Associates participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

I authorize release of my medical information to the Health Information Exchanges in which Cleburne/Joshua Family Medicine Associates:

_____ Yes_____No

Print Patient Name: _____. **Date of Birth: _____.**

Patient Signature: _____. **Today's Date: _____.**

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Family Medicine Associates
CLEBURNE • JOSHUA
A member of the Veritas Physician Group

Patient History

Name:_____ **DOB:**_____

ALLERGIES *List all known allergies and reactions*: _____

_____

MEDICATIONS

List all current medications, prescription and nonprescription (EXAMPLE: ASPIRIN, HERBALS, VITAMINS):

Medication	Dose	Frequency	Start Date

MEN ONLY:

	YES	*Date*		*YES*	*Date*		*YES*	*Date*
Prostate Problems			Prostate Cancer			Cancer of the Testicles		

WOMEN ONLY:

Abnormal Pap Smear			Cervical Cancer			Ovarian Cancer		

Pregnancies:	Deliveries:	Miscarriages:	Abortions:
Method of Birth Control if Applicable:	**Date of Last Menstrual Period:**	Could you be pregnant? _____ Yes _____ No	

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HEALTH MANAGEMENT:

Please indicate when you last had each of the following exams and if the results were normal /abnormal:

	Date	Normal	Abnormal		Date	Normal	Abnormal
Dental				Bone Density Test/DEXA			
Ophthalmology				Mammogram (female)			
Stress Test				Pelvic/Pap Smear (female)			
Colonoscopy (over age 50)				Breast exam (female)			
Stool test for blood				PSA Exam (male)			
Chest X-ray				Rectal/Prostate Exam (male)			
Tuberculosisskintest(PPD)				Tetanus Shot			
Pneumonia Shot				Flu Shot			
Hepatitis A & B				Shingles Shot			
Gardasil Shot(s) (female)				Other: _____			

MEDICAL HISTORY (*Check all that apply***)**

	YES	***Date***		***YES***	***Date***		***YES***	***Date***
Hypertension (High Blood Pressure)			TB (Tuberculosis)			Other Arthritis		
Stroke			Pneumonia			Gout		
Seizures			Emphysema (COPD) or Chronic Bronchitis			Osteoporosis/osteopenia		
Migraines			Heart Abnormalities			Skin disease		
Anemia			Congestive Heart Failure			Phlebitis/blood clots		
Lung cancer			Myocardial Infarction (Heart Attack)			Anemia		
Breast cancer			Mitral Valve Disease			Bleeding disorder		
Colon cancer			High Cholesterol			Depression		
Skin cancer			Coronary Artery Disease			Anxiety		
Other cancer: _____			Psychiatric			Chicken Pox		
Hyperthyroid			Heart Murmur			Measles		
Hypothyroid			Heart Valve Disease			Mumps		
Diabetes			Heart Palpitations or arrhythmias			Infectious Mono		
Stomach or Peptic Ulcer			Pulmonary fibrosis			Allergies/Hay fever		
Kidney Disease			Anyotherlungdiseasenot mentioned			Hives or Eczema		
Sleep Apnea			Hiatal hernia/GERD			Blood Transfusion		
Liver Disease			Gallstones			Bladder Infections		
Hepatitis			Pancreatitis			Hemorrhoids		
AIDS/HIV			Colitis (not spastic colon)			Hernia		
Sexually Transmitted Disease			Spastic colon or irritable bowel			Back Problems		
			Kidney stones			Other: _____		
Cataract			Kidney infections			Other: _____		
Glaucoma			Rheumatoid arthritis			Other: _____		
Asthma			Osteoarthritis			Other: _____		

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Concussion	YES	Date	Broken Bones/Fractures	YES	Date

SURGICAL HISTORY

	YES	Date		Date
Cholecystectomy (Gallbladder)			Other:_____	
Appendectomy			Other:_____	
Tonsillectomy				
Hysterectomy				

FAMILY HISTORY

Please indicate in the spaces below any family members with a history of: diabetes, heart disease, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, high blood pressure, gout, arthritis, ulcer, stroke, nervous breakdown, gallbladder disease..

Family Member	Age if Living	Health Problems	Age at Time of Death	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers (How many in all?_____)				
Sisters (How many in all?_____)				
Sons (How many in all?_____)				
Daughters (How many in all?_____)				
Other family members				

SOCIAL HISTORY

Your Personal Habits: Do you?	YES	NO	Date Quit	If Yes, how much/how often?
Smoke				
Drink Alcohol				
Use recreational/Intravenous street drugs				

Do you exercise on a regular basis? ☐ Yes ☒ No
If so, how much and how often? _____

Do you drink caffeine? Yes ☐ No ☐
If so, how much and how often? _____

Do you always use your seatbelt when you drive or ride in a vehicle? ? ☐ Yes ☐ No

Do you play sports? Yes ☐ No ☐
If so, please list all sports participated in throughout the year: _____

_____

Family Medicine Associates
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Family Medicine Associates, P.A.
Physician Ownership Disclosure Form

To: The Patients of Family Medicine Associates, P.A. (FMA)

During the course of your physician/patient relationship with providers at Family Medicine Associates, P.A., your provider may refer you to an outside Facility for the continuance of your care.

In connection with any referral to outside Facilities, you are hereby advised that your provider may have an ownership interest in the Facilities listed below and therefore may receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you at the time of your FMA provider's first contact with you as a patient to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician, the physician's staff, or any member of Family Medicine Associates, P.A. if you choose to use a different facility.

J. Stan Johnson, M.D.
Cleburne Diagnostic Testing, LP
Laser Rejuvenation
Frontera

McDavid M. Mahaffey, M.D.
Medical Director of Heritage Trails Nursing & Rehab
Medical Director at Freedom Hospice
Laser Rejuvenation
Cleburne Diagnostic, LP
Frontera

J. Mike White, M.D.
Frontera
Laser Rejuvenation
Cleburne Diagnostic Testing, LP

Janice A. Miller, M.D.
Frontera

Brian D. Wasson, M.D.
Medical Director at American Hospice

Clinton W. Twaddell, M.D.
Cleburne Surgery Center

Heather L. McKenzie, M.D.
Cleburne Diagnostic Testing, LP
Laser Rejuvenation
Frontera

Robert M. Miller, M.D.
Frontera

Crissy Welch, M.D.
Laser Rejuvenation