

Internal Medicine Associates of Dallas
Patient Registration form

(Circle one) **Joseph M. Rothstein, M.D.**

Pratik Kapadia, M.D.

Nazish Islahi, M.D.

Today's Date: _____

Chart#: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: (Street#,Name) _____ (City) _____ (State) _____ (Zip) _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: Female, Male, Unknown, Transgender

Marital Status: Divorced, Married, Partner, Single, Widowed, Legally Separated

SSN# _____

Employer Name: _____

Employed: Full time, Part time, Not employed, Self employed, Retired, On Active Military, Reserved for assignment

Student status: Full time, Part time, Not a student

Emergency contact: Are they a current patient? Yes, No

Name: (Last) _____ (First) _____ (Middle) _____

Relationship: _____

Address:(Street#,Name) _____ (City) _____ (State) _____ (Zip) _____

Phone#:(Home/Cell) _____ (Work) _____

****Insurance policy holder information: (if self-then skip to additional information)**

Are they a current patient? Yes, No

Name: (Last) _____ (First) _____ (Middle) _____

Relationship: _____

Date of Birth: _____ SSN: _____ Phone#: _____ Sex: Male Female

Address:(Street#,Name) _____ (City) _____ (State) _____ (Zip) _____

Employer name: _____

Employer address: _____

Employer Phone: _____

****Additional information**

Which number should we use to confirm appointments and contact you with results? Home, Cell, Work

Ok to leave which kind of message on the phone designated above? Brief Detailed

Race: _____ Ethnicity: Hispanic/Latino or Not Hispanic/Latino

Language: English or Spanish

Pharmacy Name: _____ Phone#: _____

Referred by: _____

PLEASE PRESENT YOUR DRIVERS LICENSE/ID AND INSURANCE CARDS TO THE CHECK IN DESK

Internal Medicine Associates of Dallas
3600 Gaston Ave., Suite 1004
Barnett Tower
Dallas, TX 75246
214-827-7600 Fax 214-827-0076

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Internal Medicine Associates of Dallas (IMAD) is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of IMAD, or any individual listed below to disclose my protected health information as described on this form. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth.

Description of the information to be used or disclosed (except for the use of psychotherapy notes.):

(Please check one) All records
 Other: _____

List below the individual(s) and their relationship to yourself that IMAD is allowed to disclose your protected health information to:

- | | |
|----------------|---------------------|
| 1. Name: _____ | Relationship: _____ |
| 2. Name: _____ | Relationship: _____ |
| 3. Name: _____ | Relationship: _____ |

Purpose of this requested uses and/or disclosure:

(Please check one) Per my request
 Other: _____

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective IMAD must receive the revocation in writing. The revocation must include:

- *The patient's name, address, and patient number, if applicable,
- *The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- *The patient's desire to revoke this authorization, and
- *The date of the revocation, and the patient's signature.

IMAD will accept written revocations of this authorization via certified or fax. All revocation must be sent to Attention: Privacy Officer. Revocation are not effective until received by the privacy officer.

I fully understand and accept the terms of this authorization.

Patient signature: _____ Date: _____

If this form is signed by a personal representative for the individual patient, complete the following:

Personal Representative's
Name: _____ Relationship: _____

Signature: _____ Date: _____

Authorization accepted by IMAD on _____.

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

**INTERNAL MEDICINE ASSOCIATES OF DALLAS
3600 GASTON AVENUE, SUITE 1004
BARNETT TOWER
DALLAS, TX 75246
214-827-7600**

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Internal Medicine Associates of Dallas to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient

Date

Witness

Date

INTERNAL MEDICINE ASSOCIATES OF DALLAS

3600 Gaston Ave., Suite 1004
Barnett Tower
Dallas, TX 7524
214-827-7600 Fax 214-827-0076

NOTICE OF PRIVACY PRACTICES

Effective Date: 6/2013

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 about this Notice, please contact:

The Office Manager at Internal Medicine Associates of Dallas (IMAD)

WHO WILL FOLLOW THIS NOTICE?

- IMAD providers
- IMAD employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at IMAD, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

IMAD shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;

HIPAA/HITECH Privacy Compliance Manual

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- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- IMAD will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run IMAD in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, IMAD may provide a written or telephone reminder that your next appointment with Dr. (appointment providers name) is on (date) at (time).
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
 - To prevent or control disease, injury, or disability;
 - To report reactions to medications or problems with products;
 - To notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
 - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order or subpoena; or
 - If IMAD determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.*, to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for IMAD. If you request a copy of the information, IMAD may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

IMAD may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by IMAD will review your request and denial. The person conducting the review will not be the person who denied your request. IMAD will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask IMAD to amend the information. You have the right to request an amendment for as long as the information is kept by IMAD.

To request an amendment, your request must be made in writing and submitted to IMAD. In addition, you must provide a reason that supports your request.

IMAD may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, IMAD may deny your request if you ask us to amend information that:

- Was not created by IMAD, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by IMAD;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

To request this list you must submit your request in writing to IMAD office manager. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month

period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. IMAD will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information IMAD uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information IMAD discloses about you to someone who is involved in your care or the payment for your care.

IMAD is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which IMAD has been paid out of pocket in full. Should IMAD agree to your request, IMAD will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to IMAD. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit IMAD's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that IMAD communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that IMAD contact you only at work or by mail.

To request that IMAD communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. IMAD will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with IMAD or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with IMAD, contact the Privacy Officer. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

*Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202*

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number XXX-XX-____

I acknowledge that IMAD provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature

Date

Personal Representative Signature (if applicable)

Relationship to Patient

Consent for Patient Portal

Internal Medicine Associated of Dallas offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

*How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

*Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present.

- We need you to make sure we have your correct email address and are informed if it ever changes.
- Your current email address is: _____.

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

PATIENT PORTAL SHOULD NOT BE USED FOR MEDICAL EMERGENCIES.

IMAD will make every effort to read and respond to an e-mail from you. IMAD cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Therefore, should you need immediate assistance, please call IMAD or your physician's office.

By consenting to communicate with IMAD through e-mail, you also agree to the following responsibilities:

- If you send an e-mail to IMAD that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify IMAD that the e-mail was received. You cannot assume that because it was not returned that it was received.
- It is your responsibility to schedule appointments.
- You should NOT use e-mail in order to make disclosures about sensitive medical information such as:
 - a. Substance Abuse
 - b. AIDS/HIV
- It is your responsibility to inform IMAD of any changes to your e-mail address.

Should you want to restrict any other kind of information that may be disclosed through the use of e-mail then do not sign this form and only use verbal communication.

Should you wish to revoke this consent, revocation must be made in written form or e-mail. In either case, the revocation must be addressed to Attn: Office Manager, who may be contacted at the following address:

Internal Medicine Associates of Dallas
3600 Gaston Ave #1004
Dallas, TX 75246

***Patient Acknowledgement and Agreement**

I acknowledge that I have read and fully understand this consent form and the attached Policies and Procedures Regarding the Patient Portal. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Patient Name

Date

Patient / Personal Representative Signature (if applicable)

Relationship to Patient

ELECTRONIC MAIL POLICY

(Any telemedicine or telehealth interaction between a patient and IMAD requires informed consent before telemedicine or telehealth services are provided, consent is required not only because medical information may be obtained, transmitted, or stored during the telemedicine consultation, but also because patients are engaging in a specific medical procedure. A physician with a license in one state may be at risk of violating another state's licensing laws when engaging in e-mail consultation, diagnosis, or treatment in another state. Prior to engaging in an electronic consultation with or about a patient, IMAD should be aware of potential licensing issues. Because of the risks associated with e-mail, it is recommended that IMAD not engage in this practice. However, this may not be realistic in the current practice environment. If e-mail is used, the e-mail to and from the patient must be encrypted as required by HITECH.)

***PURPOSE:** To establish appropriate safeguards for the transmission of electronic mail ("e-mail").

***POLICY:** Workforce members must use discretion in transmitting PHI by e-mail. All such transmissions shall comply with this e-mail policy and with HITECH encryption requirements (see Security Manual). It is recognized that e-mail is a vital form of communication and is used to facilitate the delivery of care. When transmitting information via e-mail or the Internet, the security of the transmission cannot necessarily be guaranteed. Therefore, IMAD MUST obtain a patient's informed consent prior to making ANY disclosure of PHI through e-mail. If a patient refuses to sign the consent form, DO NOT communicate with patients through e-mail.

When obtaining consent for the use of e-mail transmissions, IMAD shall:

- Explain the inherent risks and benefits to the patient;
- Inform the patient of who might see patient e-mail messages, such as office staff, consultants, or those covering during workforce members absences;
- Inform the patient that e-mail correspondence will be printed and placed in the patient's record;
- Inform the patient of appropriate response times;
- Configure an auto-reply to acknowledge receipt of patient's e-mail; and
- Not forward e-mail to third parties without the patient's consent.

A face-to-face consultation between a patient and a physician providing a telemedicine medical service is required, if the physician has never seen the patient, within a certain number of days following an initial telemedicine medical service. Please see Texas Medical Board ("TMB") Rules on use of the internet in medical practices.¹

When utilizing the internet, IMAD shall ensure a proper physician-patient relationship is established that at a minimum includes:

- (1) establishing that the person requesting the treatment is in fact who the person claims to be;
- (2) establishing a diagnosis through the use of acceptable medical practices such as patient history, mental status examination, physical examination, and appropriate diagnostic and laboratory testing to establish diagnoses and identify underlying conditions and/or contra-indications to treatment recommended/provided;
- (3) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options; and
- (4) ensuring the availability of the physician or coverage of the patient for appropriate follow-up care.

Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (face-to-face) settings. An online or telephonic evaluation by questionnaire does not constitute an acceptable standard of care.

When using electronic communications, IMAD must maintain:

- (1) written policies and procedures for physician-patient communications, which are evaluated periodically for currency and address:
 - (A) privacy to assure confidentiality and integrity of patient-identifiable information;
 - (B) health care personnel, in addition to the physician, who will process messages;
 - (C) hours of operation and availability;
 - (D) types of transactions that will be permitted electronically;
 - (E) required patient information to be included in the communication, such as patient name, identification number and type of transaction;
 - (F) archival and retrieval; and
 - (G) quality oversight mechanisms.
- (2) All patient-physician e-mail, as well as other patient-related electronic communications, must be stored and filed in the patient's medical record.
- (3) Patients must be informed of alternative forms of communication for urgent matters.

Patient medical records must include copies of all patient-related electronic communications, including patient-physician e-mail, prescriptions, laboratory and test results, evaluations and consultations, records of past care and instructions. IMAD staff shall not use e-mail when discussing sensitive health care information such as substance abuse, alcohol, HIV or AIDS. A list of patients who have consented to communication by e-mail shall be maintained by IMAD by noting web enabled in the software and updated on a regular basis. ¹ Currently 22 TAC Chapter 174, §174.4. The TMB has published amendments to Chapter 174. The internet provisions will be moved to Chapter 164, Section 164.6.