TOWN & COUNTRY
Family Physicians

Anthony J. Popek, MD Laurel M. Tucker, MD Henry C. Jackson, MD
Lubna Momin, NP-C Shannon Borden, NP-C
10497 Town and Country Way, Suite 360, Houston, TX 77024 Phone 713-341-2100 Fax 713-932-7072
www.townandcountryfamilyphysicians.com

REGISTRATION

PATIENT INFORMATION

Patient's Last Name: First: Middle:			SS#	TDL#
Address:	Apartment#	City:	State:	Zip:
Birth Date: Age:	Sex: □ M □ F		Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed	
Home Phone:	Cell Phone:		Work Phone:	
Email:	Race:	Ethnic Group:	Do you have an advance directive: □ No □ Yes (*please provide copy*)	
Employer:			Occupation:	
Employer Address: City: State: Zip:			Employer Phone:	
Preferred Contact Method: □ Home Phone □ Cell Phone □ Patient Portal		In Case of Emergency Who Should Be Notified: Relationship: Phone Number:		

How did you hear about us? □ TV □ Internet □ Friend □ Family □ Magazine □ Other:

PRIMARY INSURANCE (Please give your insurance card to the receptionist)

Policyholder: Last Name: First: Middle:			
Patient's Relationship to Policyholder: □ Self □ Spouse □ Child □ Other:	Birth Date:	SS#	
Address (if different from above):	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Policyholder Employer:		Occupation:	
Name of Primary Insurance:	ID#/Subscriber#	Group:	

SECONDARY INSURANCE

Policyholder: Last Name: First: Middle:		
Patient's Relationship to Policyholder: □ Self □ Spouse □ Child Other	Birth Date:	SS#
Policyholder Employer:		Occupation:
Name of Secondary Insurance:	ID#/Subscriber#	Group:

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize Town & Country Family Physicians to file my medical claims to my insurance and release medical information necessary to process any claim. I authorize payment of medical benefits to Town & Country Family Physicians. I hereby acknowledge and understand that I am financially responsible for all charges rendered to me (or my dependent) whether or not paid/covered by my insurance carrier. I authorize the use of this signature on all insurance submissions. I, the patient give consent for treatment.

Patient/Guardian Signature: _____ Date: _____

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MEDICAL HISTORY FORM

Name: _____ Sex: ☐M ☐F Date of Birth: _____ Age: _____
Last First Middle

PAST MEDICAL HISTORY

	Yes	No		Yes	No	
Heart Disease	☐	☐	Diabetes	☐	☐	**OTHER:**
High Blood Pressure	☐	☐	Thyroid/ Endocrine	☐	☐	_____
Stroke	☐	☐	Cancer	☐	☐	_____
Cholesterol	☐	☐	Muscle/ Joint Disorders	☐	☐	_____
Asthma/ Lung Disorders	☐	☐	Liver Disorder/ Hepatitis	☐	☐	_____
Allergies	☐	☐	Gastrointestinal	☐	☐	_____
Head Injury/ Seizures	☐	☐	Migraines	☐	☐	_____
Psychiatric Disorders	☐	☐	Eye Disorders	☐	☐	_____
Kidney Disease	☐	☐	STD	☐	☐	

PAST SURGICAL HISTORY

	Yes	No		Yes	No	
Cataract	☐	☐	Hernia	☐	☐	**OTHER:**
Ear Tubes	☐	☐	Hysterectomy (uterus)	☐	☐	_____
Tonsillectomy	☐	☐	Ovaries removed	☐	☐	_____
Thyroidectomy	☐	☐	Tubal ligation	☐	☐	_____
Breast Surgery	☐	☐	Vasectomy	☐	☐	_____
Heart Surgery	☐	☐	Orthopedic Surgery	☐	☐	_____
Gallbladder	☐	☐	Appendectomy	☐	☐	_____

MEDICATIONS

Regular Medications (include vitamins, over the counter, birth control, herbal meds)
(**Example**: Lipitor 20 mg, 1 a day)

	Drug	Drug Strength	Frequency		Drug	Drug Strength	Frequency
1				6			
2				7			
3				8			
4				9			
5				10			

Pharmacy Name_____ **Phone Number** _____

ALLERGIES AND REACTIONS TO MEDICATIONS

Please list any allergic reactions or other adverse reactions you have had to any medications, including over-the-counter medications. ☐**Please check this box if you have had no medication allergies or reactions.**

Name of Medication	**Allergic Reaction**	**Other Adverse Reaction**

Date of Last Immunization:

VACCINE	YES	NO	YEAR		YES	NO	YEAR
Hepatitis A	☐	☐		Typhoid	☐	☐	
Hepatitis B	☐	☐		Yellow Fever	☐	☐	
Pneumonia	☐	☐		Measles, Mumps, Rubella	☐	☐	
Polio	☐	☐		HPV (Gardasil)	☐	☐	
Tetanus	☐	☐		Influenza (yearly flu shot)	☐	☐	
Chickenpox (varicella)	☐	☐		BCG/ Tuberculosis Vaccine	☐	☐	
Meningococcal	☐	☐		Other:	☐	☐	

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed

Currently sexually active? ☐ Yes ☐ No New partner(s) in the last year? ☐ Yes ☐ No If yes, how many? _____

Do you use tobacco? ☐ Yes ☐ No Type: _____ Amount per day: _____ Duration: _____

Do you or have you use illicit drugs? ☐ Yes ☐ No Type: _____ Amount per day: _____ Duration: _____

Alcohol ☐ Yes ☐ No Amount of drinks / week: _____

Caffeine ☐ Yes ☐ No Amount of drinks / day of: coffee tea soda

Occupation _____

Military Service _____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	Health	Age	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Do you have a family history of:(Check any that apply and explain below, include blood relatives only)

☐ Diabetes	☐ Cancer	☐ Heart Disease	☐ High Blood Pressure
☐ Thyroid	☐ Stroke	☐ Glaucoma	☐ Arthritis
☐ Seizure	☐ Heritable Disorder	☐ Tuberculosis	☐ Autoimmune Disorder
☐ Alcohol Abuse	☐ Kidney Disease	☐ Migraines	☐ Asthma/Lung Disease
☐ Drug Abuse	☐ Colon Disease	☐ Mental Illness	☐ Other: _____

Please indicate which family member is/was affected and any details:

_____

_____

_____

HEALTH SCREENINGS	**MONTH/ YEAR**	**RESULT**
Colonoscopy		
Pap Smear		
Mammogram		
Bone Density (DEXA)		
Stress Test		
Endoscopy		
Other:		

PLEASE CHECK THE APPROPRIATE BOX Y= YES N= NO O=OCCASIONALLY

GENERAL

	Y	N	O		Y	N	O		Y	N	O
Fatigue	☐	☐	☐	Night Sweats	☐	☐	☐	Difficulty Sleeping	☐	☐	☐
Loss of Appetite	☐	☐	☐	Intolerance to Heat	☐	☐	☐	Bleeding Tendency	☐	☐	☐
Loss of Weight	☐	☐	☐	Intolerance to Cold	☐	☐	☐	Sexual Dysfunction	☐	☐	☐
Fever	☐	☐	☐	Any Skin Troubles	☐	☐	☐	Chills	☐	☐	☐

HEAD AND NECK

Headaches	☐	☐	☐	Nasal Congestion	☐	☐	☐	Frequent Colds	☐	☐	☐
Eye Trouble	☐	☐	☐	Nose Bleeds	☐	☐	☐	Sore Throat	☐	☐	☐
Hearing Difficulty	☐	☐	☐	Hay Fever	☐	☐	☐	Lumps in Neck	☐	☐	☐
Earaches	☐	☐	☐	Dental Trouble	☐	☐	☐	Neck Pain	☐	☐	☐
Sinus Trouble	☐	☐	☐	Sore Tongue	☐	☐	☐	Other:	☐	☐	☐

RESPIRATORY

Cough	☐	☐	☐	Wheezing	☐	☐	☐	**Date of Last Chest Xray**	☐	☐	☐
Sputum	☐	☐	☐	Shortness of Breath	☐	☐	☐	**Date of last TB skin test**	☐	☐	☐
Cough up blood	☐	☐	☐	Exposure to Tuberculosis	☐	☐	☐	**If done, was it positive**	☐	☐	☐

CARDIOVASCULAR

Chest Pain	☐	☐	☐	Swelling of Ankles	☐	☐	☐	Poor Circulation	☐	☐	☐
Varicose Veins	☐	☐	☐	Irregular Heartbeat/ Palpitations	☐	☐	☐	Other:	☐	☐	☐
Heart Murmur	☐	☐	☐	Date of last EKG	☐	☐	☐		☐	☐	☐

DIGESTIVE

Heartburn	☐	☐	☐	Difficulty Swallowing	☐	☐	☐	Nausea	☐	☐	☐
Gas	☐	☐	☐	Abdominal Pain	☐	☐	☐	Vomiting	☐	☐	☐
Constipation	☐	☐	☐	Blood in Stools	☐	☐	☐	Black Stools	☐	☐	☐
Diarrhea	☐	☐	☐	Hemorrhoids	☐	☐	☐		☐	☐	☐

URINARY

Incontinence	☐	☐	☐	Frequency of Urination	☐	☐	☐	Appearance Change of Urine	☐	☐	☐
Painful Urination	☐	☐	☐	Bloody or Discolored Urine	☐	☐	☐	Get Up at Night to Urinate?	☐	☐	☐

MUSCLE AND JOINT

Back Pain	☐	☐	☐	Pain, Stiffness, Swelling	☐	☐	☐	Limitations of Joint Movement	☐	☐	☐
Broken Bones	☐	☐	☐	Deformities	☐	☐	☐	Leg Cramps When Sleeping	☐	☐	☐
Feet Trouble	☐	☐	☐	Injuries in the Past Year	☐	☐	☐		☐	☐	☐

NERVOUS SYSTEM

Forgetfulness	☐	☐	☐	Abdominal Sensation	☐	☐	☐	Loss of Balance	☐	☐	☐
Tremors	☐	☐	☐	Nervousness	☐	☐	☐	Muscle Weakness	☐	☐	☐
Depression	☐	☐	☐	Spells of Any Kind	☐	☐	☐	Difficulty Walking	☐	☐	☐
Clumsiness	☐	☐	☐	Dizziness	☐	☐	☐	Fainting	☐	☐	☐

WOMEN ONLY

Menopause	☐	☐	☐	Irregular Menstruation	☐	☐	☐	Age of first menstrual period	☐	☐	☐
Breast Pain	☐	☐	☐	Abnormal Vaginal Discharge	☐	☐	☐	Age of menopause	☐	☐	☐
Breast Lump	☐	☐	☐	# of Pregnancies	☐	☐	☐		☐	☐	☐
Hot Flashes	☐	☐	☐	# of Miscarriages	☐	☐	☐		☐	☐	☐

MEN ONLY

Lump in Testicles	☐	☐	☐	Penis Discharge	☐	☐	☐	Impotence or Difficulty with Erections	☐	☐	☐
Sore Penis	☐	☐	☐	Prostate Trouble	☐	☐	☐	Difficult Urination or Weak Stream	☐	☐	☐

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician or nurse practitioner to perform tests, treatment and procedures as indicated for myself for as long as I am a patient of Town & Country Family Physicians.

_____ _____

Name of Patient Signature of Patient/Legal Representative

_____ _____ _____ _____

Relationship to Patient Date Reviewed by Date

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AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION TO A FRIEND OR FAMILY MEMBER

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner *(Check All That Apply):*

___ **Home Telephone ( )** _____
- ___ Leave message with detailed information.
- ___ Only leave message with call back details.

___ **Work Telephone ( )** _____
- ___ Leave message with detailed information.
- ___ Only leave message with call back details.

___ **Cell Telephone ( )** _____
- ___ Leave message with detailed information.
- ___ Only leave message with call back details.

___ **Email Correspondence – Patient Portal**

Email Address: _____

This office has established an **Email Policy-Patient Portal** to better serve our patients. If you provide us with your Email address, you are giving us permission to Email your test results or other personal health information. Email sent from this office is a one-way communication and return emails will not be accepted. You will need to contact this office or schedule an appointment if you have questions about any information contained in the email. Although this office is dedicated to keeping your medial record information confidential, third parties may have access to email messages despite our best efforts. You should be aware that some companies consider property and your messages may be monitored if you communicate from work. This office is not responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ **Yes,** I consent to the release of this information. ____ **No,** I do not consent to the release of this information.

Authorized Designees:

Name: _____ Relationship: _____ Telephone: (_____) - _____ - _____

Name: _____ Relationship: _____ Telephone: (_____) - _____ - _____

This authorization shall remain in effect from the date signed below until revoked. You have the right to revoke this authorization in writing.

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as long as I pay the fee for copies of medical records. I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

Patient/Legal Representative Print Name	Patient/Legal Representative Signature	Date

ACKNOWLEDGEMENT AND SIGNATURES

Welcome to Town & Country Family Physicians, we appreciate you choosing our providers to meet your healthcare needs. Our entire staff works together to make your satisfaction our number one priority. The providers at Town & Country Family Physicians are dedicated to providing you and your family members with the highest quality healthcare available. We want your visits to our office to be as comfortable as possible. Please read these policies to your treatment so that you will have a better understanding of our office policies. Sign the acknowledgement on this page and take a copy of both our office policy statement and the HIPAA policy.

ACKNOWLEDEMENT OF RECEIPT AND UNDERSTANDING OF OFFICE POLICIES

I have read, understand, and agree to abide by the policies stated on the office policy form.

_____ _____

Patient/Guarantor Signature *Date*

ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Town & Country Family

(*Print Patient's Name)*

Physicians Practice's Notice of Privacy Practices.

_____ _____

Patient/Guarantor Signature *Date*

ACKNOWLEDEMENT OF ASSIGMENT AND RELEASE

The information reported on this document is true to the best of my knowledge. I hereby authorize Town & Country Family Physicians and staff to release any information acquired in the course of my treatment to my insurance company as required for claims filed. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health. I authorize direct payment to be made to Town & Country Family Physicians. I understand that if any services or charges are not covered, or if TCFP is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

_____ _____

Patient/Guarantor Signature *Date*

_____ _____

Print Patient's Name *Date of Birth*

OFFICE AND FINANCIAL POLICY

Thank you for choosing Town and Country Family Physicians (TCFP) for your health care needs. Please carefully review our office and financial policies. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our office and financial policy form before receiving medical services. This form confirms that you understand that the services provided are necessary and appropriate, and advises you of your financial responsibility with respect to services received. I authorize Town and Country Family Physicians (herein referred to as TCFP) to provide me and/or my dependents medical care.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. Please be aware that certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", or "cosmetic" by your health plan. You may be responsible for payment of these services. Please also be aware that many health plans limit preventive coverage and that additional charges may be incurred if during the course of a physical exam the provider addresses, diagnoses or treats a problem-focused health concern. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits plan limitations and which laboratories to use in your current health care coverage. TCFP will provide medically necessary care based on patients' medical needs, not a patient's insurance coverage. Your provider is not responsible for knowing your plan's benefits and coverage limitations.

PATIENT FINANCIAL POLICY

TCFP participates with most major health plans. As a courtesy to our patients, we will file claims to the health plans we participate. Patients are responsible for payment at the time of service. TCFP does not balance bill for copays, coinsurance or deductibles.

Non-Covered Services: It is your responsibility to contact your insurance plan to determine whether a particular service is covered. If we provide you non-covered services, you are expected to pay for the visit at the time of service.

Out-of-Network Plans: It is your responsibility to confirm with your insurance company that your provider is in network. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service. We will file the claim to your insurance company as a courtesy to our patients. The same policy applies for insurance plans with no network participation. Patients are responsible to pay the amount set by the insurance plan only if agreed by TCFP.

TCFP providers are a non-participating Medicare provider, we do not accept assignment on Medicare claims. Patients will have to pay for any services at the time of the visit. We will file the claim to Medicare as a courtesy to our patients. Medicare will refund the patient. Allow 12-15 business days for them to remit payment to you.

Outstanding Balances- TCFP will send you a statement of charges for any outstanding balances. Payment is due on receipt. Outstanding balances will be collected during any future appointments. Delinquent accounts are referred to an outside collection agency.

Please be prepared to provide the front office your current insurance card at each visit. A scanned copy of your insurance card will be kept as part of your medical record. You may be asked to present a photo ID. Please notify the receptionist if your contact information including home address, phone numbers, and emergency contact has changed.

TCFP will attempt to verify insurance coverage and benefits prior to your visit. Patients are responsible to notify the office prior to scheduling if your insurance has changed. If we are unable to obtain verification of coverage including benefits, you may be asked to pay in full or reschedule your appointment at a time we are able to obtain verification of benefits. Benefits will be used to estimate your financial responsibility. However, this verification is not a guarantee by your insurance plan of coverage or payment. While we may estimate your financial responsibility for your services, the actual charges may vary based on when the claim is processed by your health plan. For same day appointments, we will verify eligibility when the appointment is made.

NSF Checks/Denied Credit Card Payments
If any method of payment is returned for insufficient funds, your account will be charged a $35.00 NSF fee. Should this happen two (2) times, you will be required to pay for future services with cash. We will no longer be able to accept this form of payment from you.

TCFP reserves the right to charge for services your health plan does pay for. Most health plans do not pay for prior authorizations, lengthy telephone conversations, pre-certifications, etc. Fee for prior authorizations is $25.00. Pre-payment is required before the provider is able to start the authorization process.

Due to the increase cost of doing business, it has become necessary for TCFP to charge the patient an administrative fee for bio-hazard disposal, educational materials. Your health plan does not cover this cost and it will be collected at the time of service. Currently the charge is $2.00 per visit but this is subject to change without prior notice. Administrative fees will not be billed to your health plan.

Paper format requests for medical records will be assessed a charge of $25.00 for the first 20 pages and $.50 cents per page thereafter. There will also be a $25.00 fee for billing records. Also, a reasonable fee not to exceed $15.00 for executing an affidavit. Payment will be required in advance. Please allow fifteen (15) business days for processing. If we need to mail records, a flat fee of $7.00 will be assessed also.

Late Arrivals, Cancellations and No shows:
Late Arrivals. If you arrive more than 15 minutes late for a scheduled appointment, we reserve the right to reschedule your appointment. You can wait for an open appointment time on that day's schedule with any provider at TCFP.

Cancellations. If you are unable to keep a scheduled appointment, you must call at least 24 hours before the appointment time or we may consider you a "no-show."

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed office visit and $75.00 fee for a missed physical. This fee will need to be paid before you schedule another appointment. This fee cannot be billed to insurance.

TCFP is not a walk-in clinic. We work by appointment only.

Provider/Patient Relationship: Either party can terminate this provider/patient relationship at any time with written notice. We make every effort to accommodate our patients. Our exam rooms are very small. We request that you do not ask for two patients to be seen in the same room, i.e., husband and wife, several children, etc.

Office Hours: Monday- Friday: 8:00am - 5:00pm (closed for lunch Wednesdays 12:00pm - 2:00pm and Fridays 12:00pm - 1:30pm).

Telephone Calls: Medical questions will be referred to the medical assistant or provider. You will be asked to leave any messages with one of the receptionists, the medical assistants set time aside daily to return calls. Please be aware we see patients all day so your call may not be returned until the end of the day. Calls received after 3:00pm are returned the next business day. If your concern is urgent and cannot wait until then, you must notify the receptionist. If your call is considered a true emergency, you will be asked to go straight to the nearest emergency room or call 911. Please DO NOT leave voice messages for emergencies; go straight to the nearest emergency room or call 911.

Extended phone consults or after-hour and weekend calls resulting in telephone treatment, may be billed a telephone consultation fee from $25.00-$35.00. Fee will not be billed to your health plan.

Call our 24-hour Answering Service at (281) 812-7325 after 5 p.m. to reach the provider on call.

Medication Refill Policy: We are set up to accept electronic prescription refills. For your convenience and safety prescriptions are issued during office hours only. We no longer refill medications by phone or fax. If you take medication for a chronic condition, you are required to see your provider every three (3) months. It is your responsibility to plan ahead so that you do not run out of your medications. **We require a minimum of two (2) business days turnaround time for all refill requests.**

Lab Results: Please allow two (2) weeks to obtain lab results. You will receive notification via secure email message of your test results. If you have not received notification of your results in two weeks, please call our office. TCFP will no longer mail out copies of test results. You will have to register for our patient portal services to access your medical information. Our staff will provide you with the documentation you will need in order to register.

Other Test Results: Depending on the test your provider recommended, please allow up to 2 weeks for diagnostic testing based on the date the test was done. Consultation reports, allow up to 3 weeks from the date of the consultation. Please remind the facility/specialist to provide a written evaluation and summary of findings and recommendations to your provider.

Referrals: If your doctor has evaluated you and you need a referral for that condition, please allow five (5) to seven (7) business days for your insurance company to process the referral. Insurance companies will not approve same day referrals. Do not schedule appointments without a referral, we cannot be responsible for non-coverage of incurred expenses for services rendered. Referrals will not be issued for patients without a recent office visit.

Treatment of Minors: If a parent or legal guardian would like their child under the age of eighteen (18) to be seen without the parent or guardian present, written consent will be required for each visit. Minor should be provided with a payment method to cover for the patient's responsibility.

Workers' Comp/Auto Accidents: We are not certified to treat any injuries that have occurred at your place of employment. You must contact your Human Resources Department to find out whom they require you to see. We do not bill third party payors for auto accidents or any other type of accidents. Patients are required to pay at the time of service or we can bill your health plan as long as we are in-network with the plan.

TOWN AND COUNTRY FAMILY PHYSICIANS
NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: OCTOBER 2019

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.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that your health information is personal. We are committed to protecting your health information or otherwise referred to as Protected Health Information (PHI). We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to your health information, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- make sure that health information that identifies you is kept private
- give you this notice of our legal duties and privacy practice with respect to PHI
- follow the terms of this notice that is currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

For Treatment: We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

For Payment: We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, we will follow that restriction on disclosure unless otherwise required by law.

For Health Care Operations: We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

Quality Assurance: We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

Utilization Review: We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

Credentialing and Peer Review: We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

Appointment Reminders and Health Related Benefits and Services: We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you via secure email. We may send you promotional events taking place at TCFP via email.

Business Associates: There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

As Required by Law: We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

To Avert an Imminent Threat of Injury to Health or Safety: We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

Organ and Tissue Donation: If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Research: We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

Military and Veterans: If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Workers' Compensation: We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Public Health Risks: We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- 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.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

Legal Matters: If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

Law Enforcement, National Security and Intelligence Activities: In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so.

We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Coroners, Medical Examiners and Funeral Home Directors: We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

Inmates: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

Marketing of Related Health Services: We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

Electronic Disclosures of Medical Information: Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

OTHER USES OF MEDICAL INFORMATION:

Authorizations: There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

Psychotherapy Notes, Marketing and Sale of Medical Information: Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

Right to Revoke Authorization: If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:
Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

Right to Inspect and Copy: Under most circumstances, you have the right to inspect and/or copy your medical information that may be used to make decisions about your care, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

Right to Amend: If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to: the HIPAA Officer at: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We 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, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations or disclosures made pursuant to your specific authorization, or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024 for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We 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 we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024. Original Notice has been provided to the patient.

Right to Breach Notification: In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at: Town & Country Family Physicians | Attn: HIPAA Officer | 10497 Town & Country Way, Suite 360 | Houston, TX 77024. Original Notice has been provided to the patient.

COMPLAINTS: If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Town and Country Family Physicians
Attn: HIPAA Officer
10497 Town & Country Way, Suite 360
Houston, TX 77024
(713) 341-2100

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

ACKNOWLEDGEMENT RECEIPT OF THIS NOTICE: We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you are not able to sign, a representative or a staff member will sign their name & date. This acknowledgement will be filed with your records.