TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
Your Life Behavioral Health
and Wellness Clinic

Important Clinic Information

To our valued patient,

We are grateful you have selected our clinic and clinicians to facilitate your mental health services. *Please drop off or fax the attached paperwork signed along with a copy of your insurance card and ID to our clinic prior to your appointment on* ____/____/____ at ____: ____ AM/PM. *Please arrive 15 minutes prior to your appointment time.*

Our new patient visits are 90 minutes and return visits are 50 minutes**.** *Late arrival of 15 minutes or more will result in appointment cancellation and will need to be rescheduled.* Patients who maintain a consistent attendance can book up to four (4) sessions in advance if clinic schedule permits.

What to Bring

- Insurance card & Payment
- ID/ Driver's license
- Other notes that may be helpful
- Completed & signed new patient forms
- Custody agreement outlining who has medical decision authority if parents are not married.

Location and Hours

3601 4th St STOP 6522 Lubbock, TX 79430-6522

Monday - Thursday: 9 AM - 7 PM Friday: 8:00 AM - 5 PM *Closed every day for lunch, 12 PM-1PM*

Please enter through the Texas Tech Physicians Medical Pavilion.

Our clinic is located on the third floor, Pod A Room 3A250, between the Department of Neurology and Department of Surgery.

Patient Assistance

Please contact the clinic at 806-743-2018 for questions or concerns.

For assistance with directions, please speak with a patient services representative at the information desk or call (806) 743-INFO (4636).

Designated patient parking is available at TTUHSC. Please refer to the attached parking map for information on where to park.

Clinic website: https://www.ttuhsc.edu/health-professions/your-life-behavioral-clinic/

Submitted 03.08.2023

Patients with commercial insurance and Medicaid will need a referral from their primary care physician. New patient and referral forms can be printed from our website or call 806-743-2018 to obtain a physical copy.

Self-pay patients will need to complete the new patient form. Forms can be printed from our website or call 806-743-2018 to obtain a physical copy.

Prompt Service: Schedule services as clinic schedule allows. In case of crisis outside clinic hours, please call 806-743-2018 to speak with a provider. If you are in immediate danger to yourself or others, call 911 or contact StarCare Crisis Team at 806-740-1414.

No-Show and Cancellations: A no show refers to the failure of not calling ahead to reschedule appointment. If the issue persists, you will lose the privilege of scheduling multiple sessions in advance. Having three (3) or more no-show or cancellations within a quarter in a calendar year, will result in possible patient termination.

Telehealth Counseling: For telehealth counseling services, patients are expected to have available technology and private space. Services are only provided to patients who are physically in the State of Texas. Your session may be recorded for quality assurance and education purposes. Please see the telehealth information form.

Payment: Payment is expected during your visit. Payments can be done via card, check or cash. Cash must be exact amount as we do not offer change in clinic. Self-pay patient will receive a 40% discount if service is paid full at the time of appointment.

Supervision of Children: Minors must remain supervised by a parent or guardian in the clinic. Parents or guardians must wait in the lobby or according to provider's preference. Children must not be present for couple or group therapy if they are not the patient. YLBHWC staff and clinicians are not responsible for minors in the absence of a parent or guardian.

Illness or Not Feeling Well: If you have any symptoms of illness such as fever, vomiting, diarrhea or coughing, please contact the clinic to reschedule your session.

Cellphone use: Please place your phone on vibrate mode during your session to prevent distractions. Phone calls, video and audio recordings are not permitted during your session. Please inform your provider if you expect a call during your session.

Legal Guardians: Legal guardians are expected to bring the child to the first session with supporting custody documentation. If legal guardian is unable to attend a session, a completed delegation of consent form must be in the patient's file. The form must state who will accompany the child to the session.

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
Your Life Behavioral Health
and Wellness Clinic

New Patient Questionnaire

1. Identifying Data, Chief Complaint, History of Present Illness

Patient Name: _____ DOB: _____

Age: _____Personal Pronouns: _____ Phone #: _____

Mailing address: _____

E-mail: _____ Occupation: _____

Select best way to contact: Phone Email Mail

Name and city of school/ Employer: _____

Name of person filling out this form: _____Phone #: _____

Relationship to patient: _____Are you a legal guardian? _____

Who else lives in the household? _____

Emergency contact #1: _____Phone #: _____

Emergency contact #2: _____Phone #: _____

2. Chief Complaint

Why are you requesting an evaluation? _____

Select the behaviors/ symptoms you have been experiencing: depression, mood changes, crying, hyperactivity, poor sleep, abnormal thoughts, struggle in social settings, worry, depression, mood swings, other: _____

How long have you been experiencing the above symptoms/ behaviors? _____

Have the above symptoms/ behaviors impaired or impacted your life? Y N

If yes, how? _____

Have you received a diagnosis? If so, name _____ Y N

Submitted 03.03.2023

3. Past Mental Health History

Have your ever seen a mental health professional? Y N

Have your ever been admitted for mental health/ psychiatric treatment? Y N

Are you currently receiving counseling or other mental health services? Y N

List the previous psychiatric hospitalizations. Please include the following:

Name of hospital, dates, length of stay, diagnosis/ reason for admission, medications/ treatments

List all patient treatment for mental health problems in the past. Please include the following: Name of clinic/ agency/ doctor, location, dates, problems treated, name of psychiatric medication

When did the you start having mental health symptoms?

Describe your past episodes and how they have changed over time

List all psychiatric medication taken in the past. Include: medication name, dose taken, dates, negative effects, how much it helped

4. Current/ Most Recent Episode

Describe your recent episode

When did it start?

Are there any stressors?

_____

_____

What symptoms have you experienced?

_____

_____

What treatments have you received? How did you respond?

_____

_____

5. Bio-Psycho-Social Background

Amongst your blood relatives, is there a history of the following: psychiatry hospitalizations, depression, schizophrenia, anxiety disorder, alcohol problem, drug abuse, arrests, learning disorders, prison, bipolar (manic depressions), intellectual disabilities

_____

_____

Describe problems with your birth/ infancy

_____

_____

Where you delayed, slow in learning to walk, talk or be toilet trained? Y N

Have you had to repeat any grades? Which ones? _____ Y N

Have you been in special education classes? Y N

If in school, What grade are you in? _____

6. Abuse/ Trauma

Describe any abuse or trauma the you have experienced

_____

_____

7. Neurological History

Describe if you had any of the following: severe head injuries, episodes of coma or unconsciousness, strokes, encephalitis, meningitis, other neurological illness

_____

_____

8. Substance Use

List any drug/alcohol rehab treatment or detox you have attended

_____

_____

Do you drink alcohol? How often? _____ Y N

Do you smoke? How often? _____ Y N

Do you use dip/chew tobacco? How often? _____ Y N

Have you tried to quit any of the above? How many times? _____ Y N

Select which street drug you used: speed, coke, psychedelic mushrooms, has, crank, marijuana, opium, amphetamines, crack, pot, methamphetamine, uppers, heroin, glue, downers, LSD, other: _____

Select which prescription you used: Xanax, Ativan, muscle relaxants, methadone, steroids, sleeping pills, narcotics/opioids, pain pills, barbiturates, valium

When did you last use any of the above? _____

Do you attend AA? Y N

Do you have a sponsor? Y N

9. Legal History

Describe any legal problems you have been involved in

_____

_____

Describe any past arrests or convictions. Include date, status and location

_____

_____

Do you have any children? If so, how many? _____ Y N

Are you employed? Y N

Are you married? Y N

10. Medical

List other medical conditions

_____

_____

List medication allergies

_____

_____

Date of last menstrual period _____

Are you on birth control? _____

Is there a chance you could be pregnant or intend to get pregnant? _____

Please write anything else your clinician should know:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ D.O.B: _____

Patient Signature: _____ Date: _____

Parent/ Guardian Name: _____ Phone #: _____

Parent/ Guardian Signature: _____ Date: _____

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
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Stanley Brown Safety Plan

Patient Name: _____ DOB: _____

Step1: Warning Signs (thoughts, images, mood, situation, behavior) that a crisis may be developing

(1) _____
(2) _____
(3) _____

Step 2: Internal Coping Strategies (things I can do to take my mind off my problems without contacting another person such as hobbies or other ways to relax)

(1) _____
(2) _____
(3) _____

Step 3: People and social settings that provide distractions

(1) Name: _____ Phone: _____
(2) Name: _____ Phone: _____
(3) Place: _____ Place: _____

Step 4: People whom I can ask for help during a crisis

(1) Name: _____ Phone: _____
(2) Name: _____ Phone: _____
(3) Name: _____ Phone: _____

Step 5: Professionals or agencies I can contact during a crisis

(1) Clinician Name: _____ Phone: _____
(2) Clinician Name: _____ Phone: _____
(3) Local Urgent Care Services: _____ Phone: _____
(4) Suicide Prevention Lifeline Phone: 1-800-272-8255 (TALK)

Step 6: Making the environment safer

(1) _____
(2) _____

The one thing that is most important to me and worth living for is:

_____

Texas Tech University Health Sciences Center Ambulatory Clinics **Consent to Treatment/Health Care Agreement**	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I acknowledge that TTUHSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at TTUHSC including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information.

I acknowledge that the "Notice of Privacy Practices" provides information about how TTUHSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.

ADVANCE DIRECTIVE:

Has an Advance Directive been signed?	____ YES	____ NO
If yes, is it still in effect?	____ YES	____ NO
Has a signed copy been provided to TTUHSC?	____ YES	____ NO

NOTICE OF PRIVACY PRACTICES:
I have received or reviewed a copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

I certify that I have read this form or it has been read to me*.

Date	**Print Name**	**SignaturePatient/ Legally authorized person**
Time	**Witness/Translator***	**Relationship to Patient**

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: March 3, 2016

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, 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.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory
  - 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 these cases we never share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

TTUHSC USES AND DISCLOSURES:

How do we typically use or share your health information? The following uses do **NOT** require your authorization, except where required by Texas Law.

- **Treat you**. We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services**. We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **In the case of fundraising.** We may use your PHI to contact you for fundraising efforts. We must include in any fundraising material you receive a description of how you may opt out of receiving future fundraising communications.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
    - **Help with public health and safety issues.**
        - We can share health information about you for certain situations such as:
            - Preventing disease
            - Helping with product recalls
            - Reporting adverse reactions to medications
            - Reporting suspected abuse, neglect, or domestic violence
            - Preventing or reducing a serious threat to anyone's health or safety
    - **Conducting Research**. We can use or share your information for health research.
    - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    - **Respond to organ and tissue donation requests**. We can share health information about you with organ procurement organizations.
    - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
    - **Address workers' compensation, law enforcement, and other government request.**
        - We can use or share health information about you:
            - For workers' compensation claims
            - For law enforcement purposes or with a law enforcement official
            - With health oversight agencies for activities authorized by law
            - For special government functions such as military, national security, and presidential protective services
    - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

TTUHSC RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGE IN NOTICE OF PRIVACY PRACTICES:

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhsc.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

REGIONAL PRIVACY OFFICER AT AMARILLO 1400 COULTER ROAD AMARILLO, TX 79106 (806) 414-9607	REGIONAL PRIVACY OFFICER AT LUBBOCK 3601 4TH STREET, STOP 8165 LUBBOCK, TX 79430 (806) 743-9541	REGIONAL PRIVACY OFFICER AT THE PERMIAN BASIN 800 WEST 4TH STREET ODESSA, TX 79763 (806) 743-9539

www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.

Texas Tech University
Health Sciences Center

Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications

☐ I have received a copy of the Texas Tech University Health Sciences Center (TTUHSC) Notice of Privacy Practices (rev. 3/16) in **accordance with 45 CFR § 164.520.**

Consent to Email or Text Usage for Appointment Reminders and other Healthcare Communications:

☐ I consent to receive email and/or text messaging from TTUHSC to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general health reminders or information about new services.

The cell phone number and/or email I authorize for TTUHSC to use are listed below:

Email: _____

Cell phone number: _____

TTUHSC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

By signing below, I acknowledge any options selected above, will remain in effect until further written notification by me.

Date	Print Your Name (Person signing consent form)	Signature (Patient or Other Legally Authorized Person)	
		Relationship to Patient	

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Notice to Patients of Federal Confidentiality Requirements

Under 42 CFR Part 2

Texas Tech University Health Sciences Center (TTUHSC) provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Health Professions. TTUHSC provides an array of health care services, including substance use disorder (SUD) diagnosis, treatment, and referral for treatment. As described in TTUHSC's Notice of Privacy Practices, patient medical records are protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Certain SUD patient records are also protected by the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2).

In accordance with 42 CFR § 2.22, TTUHSC is required to provide you the following summary of the federal confidentiality regulations:

1. A Part 2 Program may acknowledge that an individual is present or disclose outside the Part 2 Program information identifying a patient as having or having had a SUD under limited circumstances:
   - The presence of an identified patient in a Part 2 program which is publicly identified as a place where only SUD diagnosis, treatment, or referral for treatment is provided may be acknowledged only if the patient's written consent is obtained or if an authorizing court order is entered.

   - The regulations permit acknowledgement of the presence of an identified patient in a Part 2 program if the Part 2 program is not publicly identified as only a SUD diagnosis, treatment, or referral for treatment facility, and if the acknowledgement does not reveal that the patient has a SUD.

   - Any answer to a request for a disclosure of patient records which is not permissible under the 42 CFR Part 2 regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a SUD.

   - An inquiring party may be provided a copy of the regulations and advised that they restrict the disclosure of SUD patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.

2. Violation of the federal law and regulations by a Part 2 program is a crime and suspected violations may be reported as follows:

   - To the United States Attorney for the Northern District of Texas:

     Lubbock Office
     1205 Texas Ave., Suite 700
     Lubbock, Texas 79401-40024
     Telephone: 806-472-7351

- To the Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight at:
    - SAMHSA Opioid Treatment Program Compliance Officer
      Telephone: 240-276-2700
      Email: DPT@samhsa.hhs.gov
    - SAMHSA State Opioid Treatment Authorities (SOTA)
      Laurie DeLong
      P.O. Box 149347 Mail Code 1979
      Austin, TX 78714-9347
      Telephone: (512) 834-6700 x2146
      Email: laurie.delong@dshs.state.tx.us

3. If a patient commits a crime on the premises of the Part 2 Program or against personnel of the Part 2 Program, information related to the commission of that crime is not protected.
4. Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected.

TTUHSC is dedicated to maintaining the confidentiality of SUD patient records. If you have any questions about this notice or would like additional information, please contact the TTUHSC Office of Institutional Compliance:

TTUHSC Office of Institutional Compliance

3601 4th Street, STOP 8165

LUBBOCK, TX 79430

Telephone: 806-743-2307

Email: Compliance@ttuhsc.edu

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER

PO Box 5066, 3601 4th St., 1B108
Lubbock, TX 79430-5066
806-743-2608
1-888-300-9868 Toll Free

Consent for the Release/Disclosure of Substance Use Disorder Information

(Required by 42 CFR Part 2 and HIPAA)

*Information disclosed pursuant by this consent must be accompanied by the **Prohibition on Re-Disclosure Notice**.*

Part 1: Patient Information. I am giving permission to share my substance use disorder information, including but not limited to referrals and services for alcohol and substance use disorders.

Patient Name: _____ Date of Birth: _____ TTUHSC MRN: _____

Address: _____ City/State/Zip: _____

Telephone #: _____ Email Address: _____

Part 2: Recipient. I am the patient, or the legally authorized representative of the patient listed above and authorize TTUHSC to disclose (verbally, electronically, or any other method) my substance use disorder information and any other pertinent information that may be necessary to disclose, with the individuals and organizations listed below. **Insurance Information below must be completed for billing.**

Health Care Providers (Purpose of Disclosure: Treatment)	**Insurance Companies/3rd Party Payers (Purpose: Billing, Coordination of Care, Care Management, etc.) Insurance Information below must be completed for billing.**
1. _____ 2. _____ 3. _____ 4. _____ 5. _____	☐ Medicare ☐ Medicaid ☐ Insurance Companies listed below: 1. _____ 2. _____ 3. _____
Pharmacies (Purpose of Disclosure: Medication Prescribing)	**Other Individuals or Organizations* Purpose (please explain and indicate timeframe if needed):** _____ ***Note: This form is sufficient to authorize verbal communications with family members and friends.**
☐ Any/all pharmacies to which I ask TTUHSC to send my prescription medications for substance use disorder, now and in the future.	1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Part 3: Information to be disclosed. Choose one of the options below to let us know what information can be shared.

☐ Share all of my behavioral health and substance use disorder information (e.g., diagnosis, medications, test results, substances use history, summaries of care, clinical notes, discharge summary, social support, living situation, billing information, etc.).

☐ Share most of my behavioral health and substance use disorder information. Do NOT share the following information:

1. _____ 3. _____

2. _____ 4. _____

☐ Only share the following types of behavioral health and substance use disorder information:

1. _____ 3. _____

2. _____ 4. _____

Part 4: Your rights, permission, and signature. Read the statements below, sign, and date the form.

- I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Additional information is in TTUHSC's *Notice to Patients of Federal Confidentiality Requirements Under 42 CFR Part 2*.

- I am giving TTUHSC the permission to share my substance use disorder information. My information will be shared to help diagnose, treat, manage, and pay for my health needs. My information may be shared with the individuals or organizations listed in *Part 2*.

- I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I can have a copy of this form.

- I understand that I may revoke this consent, either in full or part of it, at any time. I understand that any information already shared because of past permission cannot be taken back.

- Unless I revoke my consent earlier, this consent will expire automatically as follows [date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]:

  Required – Specify the end date, event, or condition (for example, at the end of my treatment, upon my death, etc.):

  _____

  _____

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

- I certify that this form has been fully explained to me, I have read it or had it read to me, and I understand its contents.

_____ _____/_____/_____

Patient or Legally Authorized Signature **Date (mm/dd/yyyy)**

_____ _____

Print Your Name (Person signing consent form) **Relationship to patient**

Alternative Persons Consent to Medical Treatment of a Minor

(Only for use when parent/legal guardian cannot be contacted and has not given actual notice to the contrary)

I consent to the following surgical, medical and/or diagnostic treatment procedures for:

_____: _____
Name of Minor Patient

_____

_____

_____

The treatment will begin on: _____.
Date

The parent/legal guardian of the minor (named below) cannot be contacted and has not given actual notice to the contrary to this consent.

_____/_____
Mother's Name Father's Name

_____/_____ (if applicable)
Managing Conservator's Name Guardian's Name

DATE: _____

SIGNED: _____/_____
Relationship to Minor

WITNESS: _____/_____
Print Name

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
Your Life Behavioral Health
and Wellness Clinic

Delegation of Consent

I hereby authorize (when I am unavailable to give consent) the following individual(s), to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and behavioral health, and elective as well as emergency care as outlined below.

The person(s) who is identified below will hear personal health information of the child during the appointment. This delegation shall be valid per visit (appointment) as indicated below:

1. Name: _____ Phone#: _____

Appointment Date: _____ Appointment Time: _____

Relationship to patient: _____Patient's Provider: _____

Service Type: _____

2. Name: _____ Phone#: _____

Appointment Date: _____ Appointment Time: _____

Relationship to patient: _____Patient's Provider: _____

Service Type: _____

3. Name: _____ Phone#: _____

Appointment Date: _____ Appointment Time: _____

Relationship to patient: _____Patient's Provider: _____

Service Type: _____

Name of Parent/ Guardian: _____ Date: _____

Relationship to patient: _____Signature: _____

Witness: _____ Date: _____

Translator/ Reader (if applicable): _____ Date: _____

Texas Tech University Health Sciences Center

Confidential Communication Request

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

❑ Permission to give <u>verbal</u> protected health information or leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide <u>at least one</u> of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

❑ Permission to call the following numbers to leave messages (without disclosing protected health information): **Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.**

Phone #: _____ Phone #: _____

❑ Permission to use e-mail address for the purpose of providing information about on-line patient portal and general information about TTUHSC.

E-mail address: _____

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date

Print Your Name
(Person signing consent form)

Signature
(Patient or Other Legally Authorized Person)

Relationship to Patient

Texas Tech University Health Sciences Center
Consent and Release to Use Image or Information

I, (print name) _____
or my authorized legal representative, hereby give consent for Texas Tech University Health Sciences Center (TTUHSC) employees, students or agents to take and use information about me (including my medical history, if applicable), my name or image or likeness including, but not limited to, photographs, videotaped images, audio recordings, digital (collectively "Images"), or my data or presentation for the purposes checked below.

I AGREE TO USES DESIGNATED BELOW: ***(Not including uses for patient treatment or payment.)***	My Name	My Image(s)	My Information	My Data or Presentation
☐ For educational purposes **within** TTUHSC.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ For educational purposes **outside** TTUHSC.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ For TTUHSC marketing or publicity. (This includes news and social media such as interviews, Facebook, websites, Twitter, YouTube, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ For publication in journals or on the Internet	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Other purpose(s):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I understand that TTUHSC and its regents, employees, agents, and personnel, acting on behalf of TTUHSC, shall not be held responsible for any use of my name, information and/or image(s), including any use whatsoever by any outside user or third parties, and I hereby release and hold harmless TTUHSC and its regents, employees, agents and personnel, acting on its behalf, from any and all liability for damages of whatever kind, character or nature which may at any time result from this Consent and Release authorizing use or dissemination in accordance with the above.

I understand that TTUHSC will own the Image(s) of me for the purposes stated above. I do hereby knowingly and voluntarily waive any and all other rights, compensation, royalties, or payment of any kind or character in connection with the use of my name, likeness and/or image(s) as authorized above.

This Consent and Release can be revoked or withdrawn at any time, but such withdrawal or revocation must be in writing and sent to the TTUHSC Institutional Privacy Officer and/or local campus Regional Privacy Officer. Any withdrawal of consent does not affect any information used or disclosed prior to receipt of the written notice of withdrawal.

By signing below, I represent that I have read and understand this "Consent and Release to Use Image or Information" and that it is binding on my heirs, executors and personal representatives. I am 18 years of age or older.

_____ _____
Signature of Person Named Above Date

_____ _____
OR Signature and Print Name of Authorized Legal Representative Date

For Office Use Only:	Completed by: _____	
Date of Event: _____ ☐ Speaker	MR#: _____ ☐ Patient	R# (Banner): _____ ☐ Faculty ☐ Staff ☐ Student

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Informed Consent to Telemedicine/Telephone/Telepharmacy/Teletherapy Consultation

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

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

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

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

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

Printed Name: _____

Signature: _____
(Patient/Parent/Guardian)

Date: _____

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Your Life Behavioral Health
and Wellness Clinic

What to Expect in Your First Online (Telehealth) Appointment

Prepare your space and technology

Technology

(1) Charge your electronic device (smartphone, tablet, computer) ahead of time and keep a charger nearby.
(2) Device has a working camera, microphone and audio.
    a. Consider using headphones.
(3) Stable internet connection.

Prepare your space

(1) Be aware of your surroundings and the possibility of others hearing your session. Please make sure you are in a private space.
    a. If you have roommates, use a small fan or white noise machine to prevent others from overhearing.

Day of appointment

A patient service specialist will call you 15 minutes ahead of your appointment time

(1) You will receive a link from VitalSign6 in your E-mail. Answer the questions to the best of your ability.
(2) Pay your copay or therapy fee through the phone.

Appointment time

(1) Your assigned clinician will call you once it is your appointment time and give you the Zoom meeting code.
(2) Your clinician will ask to verify your identity and current location.
    a. Please have your ID or driver's license ready.
(3) Please treat your session as you would in person. Avoid driving and doing other tasks during the session.

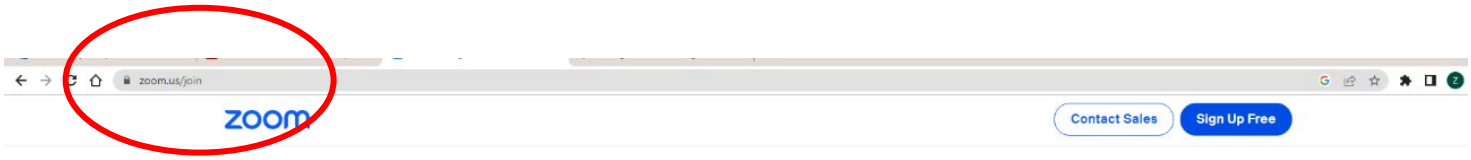
What to do if technology fails

(1) Wait 5 minutes and try to rejoin the meeting.
(2) If unable to connect, call our clinic at 806-743-2018.

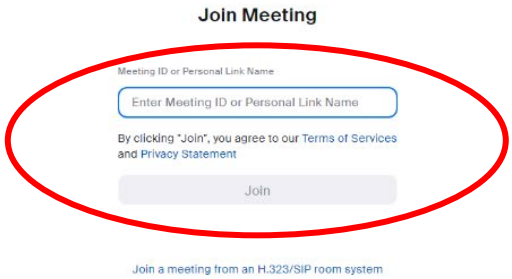
Submitted 03.03.2023

Zoom Instructions for Computer

(1) Go to join.zoom.us.
(2) Enter your meeting ID provided by the host/organizer.
(3) Click **Join**.
   a. If this is your first time joining from Google Chrome, you will be asked to open the Zoom desktop client to join the meeting.
   b. (Optional) Select the **Always open these types of links in the associated app** check box to skip this step in the future.
   c. In the pop-up window, click **Open Zoom Meetings** (PC) or **Open zoom.us** (Mac).

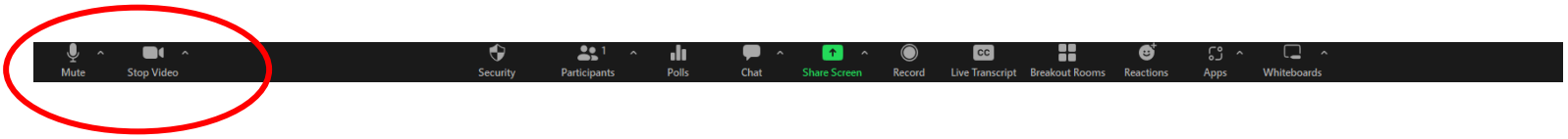


1. Go to join.zoom.us



2. Type the meeting ID provided by clinician and click join

3. Check your microphone and camera are turned on



Submitted 03.03.2023

Zoom Instructions for Mobile users

(1) Open the Zoom mobile app.

(2) Join a meeting using one of these methods:

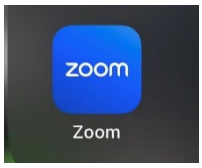
(3) Tap **Join a Meeting** if you want to join without signing in.

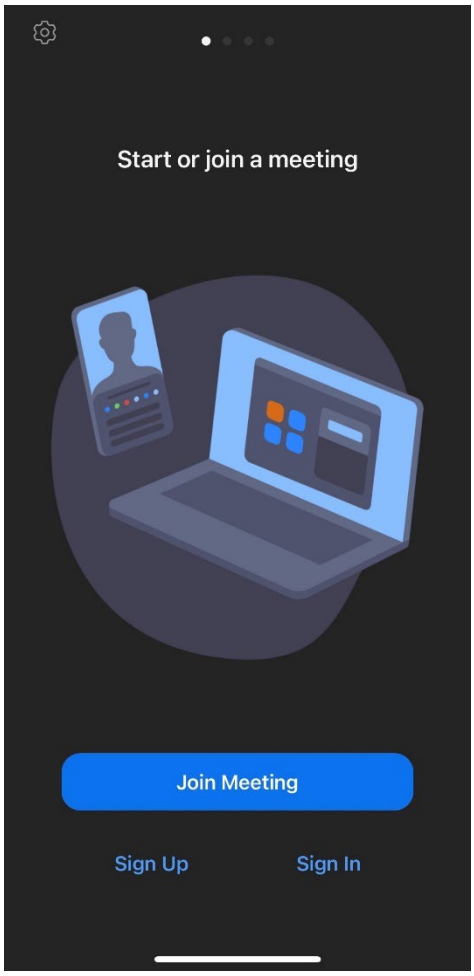
(4) Sign in to Zoom then tap **Join.**
Enter the meeting ID number and your display name.

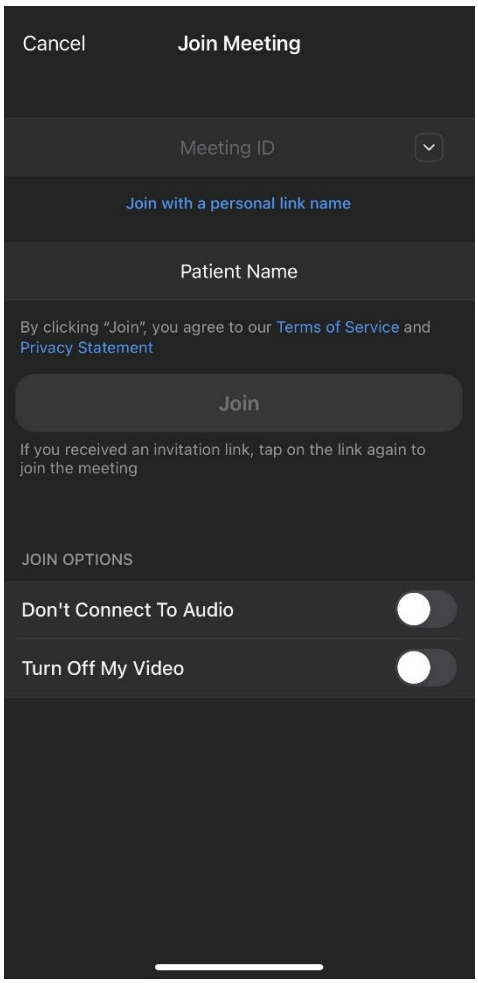
a. If you're signed in, change your name if you don't want your default name to appear.

b. If you're not signed in, enter a display name.

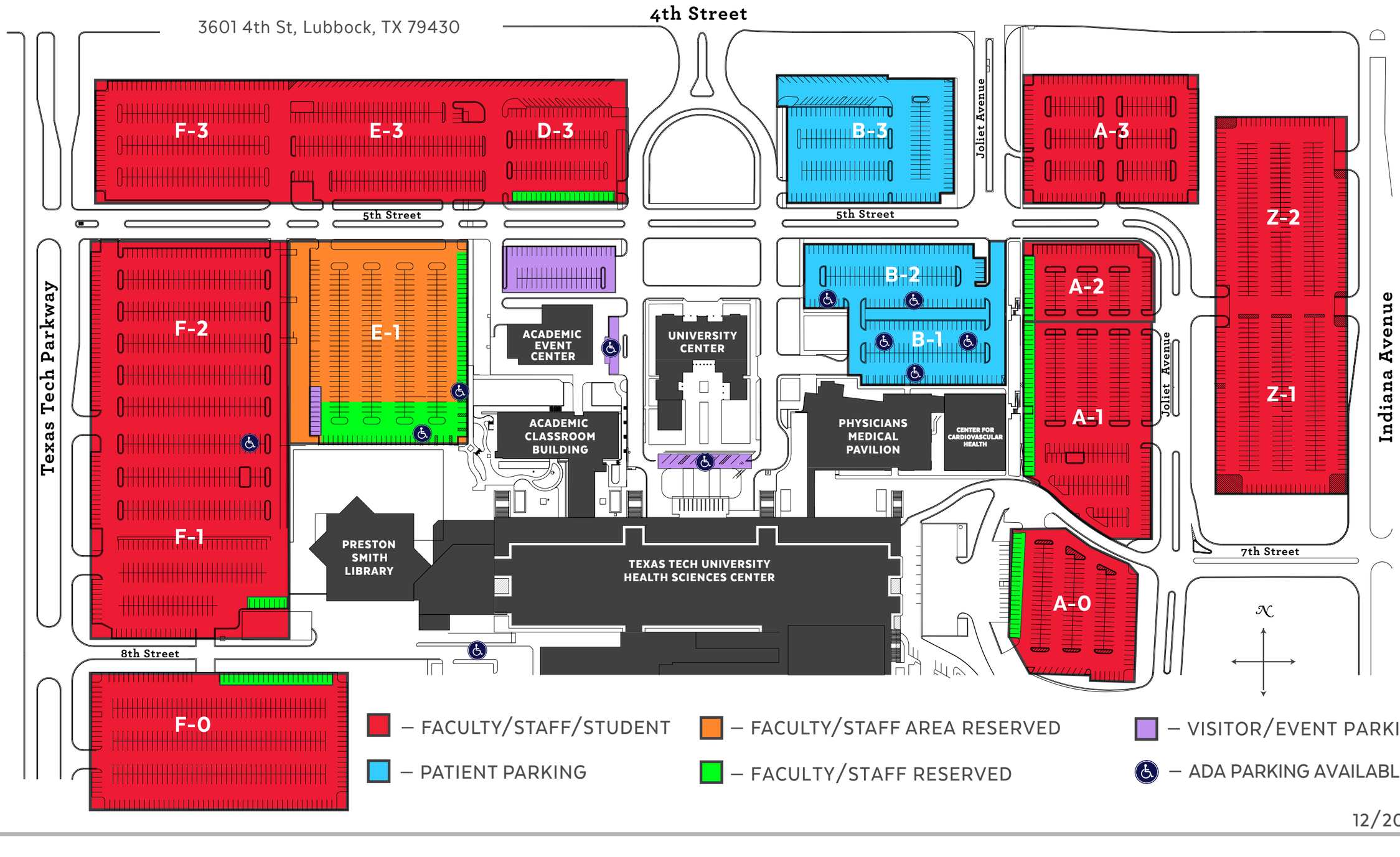
(5) Select if you would like to connect audio and/or video and tap **Join Meeting**.







TTUHSC Lubbock Main Campus Parking



12/20/21