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, identification 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 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 understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

I acknowledge that the "Notice of Privacy Practices" provides more information about how TTUHSC and its workforce may use and/or disclose protected health information (PHI). I understand that my PHI includes some but not all of the following like diagnosis, test results, prescriptions, medical history, treatment, my progress or any other such related 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"). I understand my PHI will only be used or released for treatment, payment or healthcare operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

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

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.**

USE OF CELL PHONE OR EMAIL: TTUHSC, its affiliates and agents may use an automated telephone dialing system, texting, and email to contact the cellular telephone number(s) or email addresses that I provide to TTUHSC for appointment and payment purposes.

ADVANCE DIRECTIVE:

Do you have a current, signed Advance Directive?	____ YES	____ NO
Has a signed copy been provided to TTUHSC?	____ YES	____ NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date	**Print Name**	**Signature Patient/ legally authorized person**
Witness/Translator	**Relationship to Patient**	

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
PSYCHIATRY OUTPATIENT CLINIC/SWIAD

CONFIDENTIALITY AGREEMENT

Confidentiality is an essential part of our treatment philosophy. We, therefore, ask you to sign an agreement that you will adhere to our confidentiality policy by not disclosing any information about any patient or other visitors that you may see/meet in the clinic.

I, _____ , HEREBY AGREE TO ABIDE BY THE CONFIDENTIALITY POLICY OF THE PSYCHIATRY OUTPATIENT CLINIC.

_____

Patient's Signature

_____

Date

_____

Parent's Signature (if minor)

_____

Witness Signature

//

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 verbal protected health information (including appointment information) and 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 at least one 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 #: _____

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.

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 and Relationship to Patient
(Person signing consent form)

Signature
(Patient or Other Legally Authorized Person)

Relationship to Patient

3601 4th St., MS8103
Lubbock, Texas 79430
P 806-743-2800 or Fax 806-743-2784

Texas Tech University Health Sciences Center
Patient Request for Access and/or Release of Health Information

Patient Name: _____
MRN: _____
DOB: _____

DO NOT USE THIS FORM WHEN REQUESTING PSYCHOTHERAPY NOTES.

If you would like a copy of your medical record, please complete the form below.

Patient Name _____ Date of Birth: _____
Street Address _____ Last 4 numbers of SSN: _____
City, State, Zip: _____ Telephone: _____
Email address: _____

I would like for Texas Tech University Health Sciences Center (TTUHSC) to (choose one):

☐ Give me a copy of my health information
☑ Send my records to:
☐ Release verbal information to:
☑ Receive information from:

_____
(Name of Facility, Person, Company) (Street address or PO Box, City, State, Zip Code)

_____
(Phone Number) (Fax Number)

_____
(Email Address)

I would like these dates of service to be released: _____

I want these parts of my record:

☐ Any and All records (complete record)
Only record types checked below:

☐ Progress Notes/clinic notes
☐ Laboratory Reports
☐ Immunization Record
☐ Medication Record
☐ Schedule
☑ Other (please specify) Psy Dx - Billing
☐ Billing Records (dates)
☐ Routine Record Set (Indicate date(s) of service _____
(office visits, lab, radiology, medicines, immunizations)

I agree that the following information may be released/used only as indicated below:

1. Aids/HIV test results, diagnosis, treatment, and related information — Yes ___ No ___
2. Drug screen results and information about drug and alcohol use and treatment — Yes ___ No ___
3. Mental health information — Yes ✓ No ___
4. Genetic testing — Yes ___ No ___

I want these records as a (chose one):

☐ CD
☐ Electronic
☐ Paper copy
☐ Other: _____

I want you to (choose one):

☐ Mail them
☐ Send them secure email
☐ Send them personal email (unsecure)
☐ Fax them to: _____
☐ Prepare them to be picked up by: _____

If you request your medical record to be sent to you unencrypted via your personal email, you acknowledge and accept the risk that your PHI is being transmitted through an unsecure means of communication.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this document for the patient (Written Proof may be required)

To be completed by TTUHSC:

Date of release: _____ via ☐ Mail ☐ Fax ☐ Other _____
☐ ID Verified ☐ DL/Other ID _____
Employee Name: _____ Date: _____

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
E Marie Hall Institute for
Rural and Community Health

Patient Name:
DOB:
Medical/TDCJ #:
Provider Name:
Telemedicine site:

Informed Consent to Telemedicine/Telepharmacy Consultation

I have been asked by my healthcare provider to take part in a telemedicine/telepharmacy consultation with Texas Tech University Health Sciences Center (TTUHSC) and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine/telepharmacy consult is done through a two-way video link-up whereby the physician or other health provider at TTUHSC can see my image on the screen and 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 the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The TTUHSC and affiliated telemedicine/telepharmacy consultants can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I 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 by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine/telepharmacy consult or associated with any use by TTUHSC.
10. I understand I can make a complaint of my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as "agree" and I do not agree to any that I have initialed as "decline."

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize TTUHSC and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ **Time:**_____ **am/pm**

Signature:_____ **Printed Name:**_____

Witness: _____ **Interpreter (if applicable):**_____

Texas Tech Physicians.
PSYCHIATRY

Patient Label:	

Patient Review of Systems

Thank you for choosing Texas Tech Physicians of Lubbock, Department of Psychiatry to be your healthcare provider. Please take a moment to complete prior to your appointment with your healthcare provider. Please circle any of the following symptoms below.

Who is your current primary care provider: _____

When was your last appointment: _____

Constitutional: fever, chills, sweats, weakness

Eye: recent visual problems, Icterus, discharge+, blurring, double vision, visual disturbances

ENMT: ear pain, sore throat, congestion, hoarseness.

Skin: jaundice, rash, lesions, petechiae

Respiratory: shortness of breath, cough, orthopnea, wheezing

Cardiovascular: chest pain, palpitations, edema

Gastrointestinal: nausea, vomiting, diarrhea, GI bleeding

Genitourinary: dysuria, hematuria, discharge, pain

Hema/Lymph: bruising tendency, bleeding tendency, swollen lymph glands

Immunologic: immunocompromised, recurrent fevers, recurrent infections, malaise

Musculoskeletal: back pain, trauma

Integumentary: rash, pruritus, abrasions, breakdown, burns, dryness, petechiae, skin lesion

Neurologic: headache, dizziness, numbness, weakness

Psychiatric: sleeping problems, irritability, mood swings/depression

Allergy/Immunologic: seasonal allergies, food allergies, recurrent infections, impaired immunity

Notes:

_____
_____
_____
_____
_____
_____
_____