1800 Garner Field Road • Uvalde, TX 78801 • PH (830) 278-4453 • FAX (830) 278-3427

Welcome to Uvalde Family Practice Association. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality of care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits and have early availability with our physicians. You will need to bring your insurance card and driver's license or identification with you for each appointment and verify your date of birth. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late.

We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription(s) and over-the-counter medications with you at each visit.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.
Our office policy for a missed appointment is: two (2) no-show appointments without a phone call may result in dismissal from the practice.

Providing the highest quality of professional care to our patients is very important to us.
Office hours for patient care are 8:30 am – 5:30 pm
If you need to reach the provider after hours, you can always utilize our answering service at (830) 278-4453.
Prescription Refills: Please call the pharmacy first and give UFPA 3 business days to send in prescription refills.
To schedule labs please call the office.

Welcome to our practice and thank you for choosing Uvalde Family Practice Association
for all your health care needs.

______________________________ ______________________________

Patient Name (Print) Patient/Guardian Signature

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New Patient Application

Please fill all the information completely, return back to UFPA or fax to 830-278-3427

Primary Care Physician: Cecilia Jo Murillo, MD Date: _______________

Name of Patient: _____________________________________ Date of Birth: ____________

Telephone Number: ______________________ Work Number: _______________________

Address: ____

Previous Doctor: ____

Medication(s): ____

Nature of Problem(s): ____

____

Pregnant: ☐Yes ☐No If yes, how far along? _____________________________________

Insurance: ____

Policy # _____________________ Group# _____________________

Secondary Insurance: ____

Policy # _____________________ Group# _____________________

Are you related to anyone being seen in the practice? ___________________________________

For New Patient Children Applications Only:

☐I do agree to vaccinate my child according to CDC recommendations.

☐I refuse to vaccinate my child according to CDC recommendations.

For Office Use Only

Accepted: ______________ Declined: _______________ Date Notified: ______________

Comments:

____

____

Physician Signature: ______________________________ Date: _____________________

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Patient Consent for HIPAA

I understand that I/the patient have certain rights to privacy regarding my/the patient's protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my/the patient's protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my/the patient's protected health information and my/the patient's rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I/the patient have the right to request restrictions on how my/the patient's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Patient Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Uvalde Family Practice Association and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Uvalde Family Practice Association.

I authorize payment of medical benefits to Uvalde Family Practice Association physicians or their designee for services rendered.

I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name (printed): ____

Patient/Guardian Name (signature): _____________________________________

☐Self ☐Relationship to Patient __________________________________

Patient Rights and Responsibilities

When you are seen by an employee of Uvalde Family Practice Association:

You have the Right:

- To be treated with consideration, respect and dignity.
- To have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand.
- To have privacy during case discussion, counseling and treatment.
- To know the name and qualifications of staff providing your care.
- To know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand.
- To expect that all services, treatment, and counseling techniques will take place with your informed consent.
- To participate in referral planning, if needed.
- To refuse to participate in research studies.
- To have another individual present in the exam room with you, if you so desire.

You have the Responsibility to:

- Treat the staff with consideration, respect and dignity.
- Understand that your life-style does affect your health.
- Take an active part in your health care.
- Follow the agreed upon treatment plan.
- Observe facility rules and regulations that are for the safety and consideration of all patients and staff.
- Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.

Patient Name (printed): ____

Patient/Guardian Signature: _____________________________ Date____________

☐Self ☐Relationship to Patient _______________________________________

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Authorization for Release of Information to Family Members or Family Caregivers

Patient Name: ___________________________________ Date of Birth: _____________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

☐ I do not authorize to release my medical and/or billing information.

☐ I authorize Uvalde Family Practice Association to release my medical and/or billing information to the following individual(s):

1. _________________________________ Relationship to Patient: ________________

2. _________________________________ Relationship to Patient: ________________

3. _________________________________ Relationship to Patient: ________________

Patient Information

I understand I have the right to revoke this authorization at any time, any revocation must be in writing.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. Uvalde Family Practice Association has no control over third party dissemination of protected medical information.

Patient/Guardian Signature: __________________________________ Date: ______________

Patient/Guardian Name (printed): ____

Authorization Form
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below:

Patients Name: ____ Date of Birth: _____________________

The health information you may release subject to this authorization is as follows:

____

Release my protected health information to the following entity:

Uvalde Family Practice Association
1800 Garner Field Road
Uvalde, Texas 78801
Fax Number: (830) 278-3427

The reason or purposes for this release of information are as follows:

____

This authorization shall be in force and effective until the following event and/or date: ___________________________

I understand that I have the right to revoke this authorization in writing, at any time by sending a written notification to the following:

Uvalde Family Practice Association

I understand that the revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations. The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

____ ____

Signature of Patient or Personal Representative Date

____ ____

Name of Patient or Personal Representative Description of Personal Representative's Authority

TELEMEDICINE PATIENT CONSENT FORM

I, ______________________________________ (name of patient or parent/guardian), agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a healthcare provider in person.

5. I understand that medical records of telemedicine services will be kept at Uvalde Family Practice Association.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my medical care.

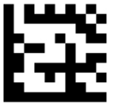
I hereby authorize the health care providers at Uvalde Family Practice to use telemedicine in the course of my diagnosis and treatment.

____
Signature of Patient (or person authorized to sign for patient)

Date: __________________________

If authorized signer, relationship to patient: ____________________________

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form



(Please print clearly)

Child's First Name ____ Child's Middle Name ____ Child's Last Name ____

Child's Date of Birth (mm/dd/yyyy) ___/___/_____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone ___-___-____

Child's Address ____ Apartment # ____ Email address ____

City ____ State ____ Zip Code ____ County ____

Mother's First Name ____ Mother's Maiden Name ____

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name ____

Date ____ Signature ____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.

DO NOT fax to ImmTrac2. **Retain this form in your client's record.**