Uvalde Family Practice Assn.
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 providers. 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. If your insurance does not cover the complete visit, the patient is responsible for the amount owed. You may be asked to sign an Advance Beneficiary Notice (ABN), also known as a waiver of liability. This is a notice a provider will give you before you receive a service if, based on insurance coverage rules, your provider has reason to believe insurance will not pay for the service.

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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Patient Information Form

Patient Demographics

_____ _____ _____

First Name Middle Name Last Name

Date of Birth ____ / ____ / ____ Language _____ SSN _____

_____

Mailing Address Apt.# City State Zip Code

(_____)_____-_____(_____)_____-_____

Home Phone Number Mobile Phone Number Email Address

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Gender: ☐Male ☐Female

If Married Spouse's Name: _____ Spouse's Employer _____

Race: ☐African American ☐American Indian/Alaska Native ☐Asian ☐Hispanic ☐Mixed Race ☐White ☐Other ☐Refuse to Report

Ethnicity: ☐Hispanic ☐Not Hispanic ☐Refuse to Report

Pharmacy

Preferred Local Pharmacy: _____

Emergency Contact Information

_____

Contact Name Phone Number Relationship to Patient

Do you have a medical directive? ☐YES ☐NO Do you have a power of attorney? ☐YES ☐NO

Patient Employment Information

_____(_____)_____-_____

Employer Name Employer Phone Number

Medical Insurance Information

_____ / _____ / _____

Policy Holder's Name Policy Holder's SSN Policy Holder's Date of Birth

_____(_____)_____-_____

Policy Holder's Address Policy Holder's Phone Number

_____

Insurance Company Group Number Policy Number

Do you have secondary insurance? ☐YES ☐NO If yes, please list: _____

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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 _____

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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): _____

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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: _____

Name of Facility/Physician Name _____

Phone number _____ Fax Number _____

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

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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: _____

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Immunization Policy

Uvalde Family Practice Association believes that on-time vaccination throughout childhood is essential because it helps provide immunity before children are exposed to potentially life –threatening diseases and/or exposing others in their community. Vaccines are tested to ensure they are safe and effective for children to receive at the recommended ages. Your primary care physician, Dr. Cecilia Murillo, strongly encourages to follow the CDC Immunization Schedule with the primary concern of ***safety*** for all our patients and their families.

Families who choose not to vaccinate will:

1. be counseled about their concerns regarding immunizations;
2. must complete the Refusal to Vaccinate form, and
3. be required to request an affidavit from the state and have it notarized for school/daycare & must be renewed yearly. **https://co-request.dshs.texas.gov/**

Our goal at Uvalde Family Practice Association is to ensure healthy children and a safe environment for all. Throughout the day we care for infants too young for vaccines, medically-fragile children/adults, and immunocompromised children/adults who are at added risk. Therefore, we strongly recommend vaccinations. It is a pleasure to care for you and honored that you entrust the care of your children to Uvalde Family Practice Association.

Cecilia Jo Murillo, M.D.

☐ I agree to vaccinate my child according to CDC Immunization Schedule in conjunction with my provider's advice.

☐ I refuse to vaccinate my child.

Print Patient Name (printed) _____

Parent/Guardian Name (printed) _____

Parent/Guardian Name (Signature) _____ Date _____

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female

Telephone _____-_____-_____ Email address _____

Child's Address _____ Apartment # / Building # _____

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			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas 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 the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 _____ Signature _____ Date _____

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)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • https://www.dshs.texas.gov/immunize/immtrac/
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations

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TEXAS Health and Human Services | Texas Department of State Health Services

REGISTRO DE INMUNIZACIÓN DE TEXAS (ImmTrac2)

Consentimiento para menores de edad

Si el cliente es menor de 18 años, uno de los padres, el tutor legal o el titular de la custodia debe firmar este formulario.

Primer nombre del menor _____ Segundo nombre del menor _____ Apellido del menor _____

Fecha de nac. del menor (mm/dd/aaaa) ____/____/____ Sexo del menor: ☐ Femenino ☐ Masculino Teléfono ____-____-____ Correo electrónico _____

Dirección del menor _____ Núm. de apartamento o edificio _____

Ciudad _____ Estado _____ Código postal _____ Condado _____

Nombre de la madre _____ Apellido de soltera _____

Raza (seleccione todos los que correspondan):

☐ Indio americano o nativo de Alaska ☐ Asiático ☐ Negro o afroamericano
☐ Nativo de Hawái o de otra isla del Pacífico ☐ Blanco ☐ Otro
☐ Se negó a contestar

Grupo étnico (seleccione solo una):

☐ Hispanic o latino
☐ No hispano o latino
☐ Otro

El Registro de Inmunización de Texas (ImmTrac2), es un servicio gratuito del Departamento Estatal de Servicios de Salud (DSHS) de Texas. Se trata de un servicio seguro y confidencial que consolida y guarda los registros de vacunación de su hijo (hasta los 18 años de edad). Con su debida autorización, la información de las vacunas que recibe su hijo se incluirá en el Registro de Inmunización de Texas. Médicos, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso a esta información para verificar que no falten vacunas importantes. Para más información consulte la sección 161.007 (d) del Código de Salud y Seguridad de Texas en *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consentimiento para incluir en el registro a un menor y para divulgar sus datos a las entidades autorizadas

Entiendo que, al dar aquí mi consentimiento, autorizo la divulgación de mis datos de vacunación al DSHS, y entiendo además que el DSHS incluirá esta información en el Registro de Inmunización de Texas. Una vez que los datos de las vacunas de mi hijo estén en el Registro de Inmunización de Texas, las siguientes entidades tendrán, por ley, acceso a ella: un distrito de salud pública o departamento de salud local, por razones de salud pública, dentro de sus zonas de jurisdicción; un médico u otro proveedor de salud legalmente autorizado para aplicar vacunas, como parte del tratamiento al menor como su paciente; una dependencia estatal que tenga la custodia legal del niño; una escuela o guardería en la que el niño esté inscrito; un pagador autorizado por el Departamento de Seguros de Texas para operar en Texas lo relacionado con la cobertura del menor. Entiendo que puedo retirar este consentimiento en cualquier momento, llenando y enviando el formulario Withdrawal of Consent al Texas Inmunization Registry del Texas Department of State Health Services.

La ley estatal permite la inclusión de los registros de vacunación de los socorristas y sus familiares directos en el Registro de Inmunización de Texas. Se define como "socorrista" al empleado de la seguridad pública o voluntario cuyas funciones incluyen el responder rápidamente a una emergencia médica. Se define como "familiar directo" a los padres, cónyuges, hijos o hermanos que viven en el mismo hogar que el socorrista. Para más información, consulte la sección 161.00705 del Código de Salud y Seguridad de Texas. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Marque la casilla de abajo para indicar si su hijo es familiar directo de un socorrista.

☐ **Soy FAMILIAR DIRECTO de un socorrista.**

Con mi firma a continuación, DOY mi consentimiento para el registro. Deseo INCLUIR los datos de mi hijo en el Registro de Inmunización de Texas.

El padre o madre, tutor legal o titular de la custodia:

Nombre escrito a mano _____ Firma _____ Fecha _____

Aviso de confidencialidad: Con ciertas excepciones, usted tiene derecho a solicitar y recibir información sobre los datos que el estado de Texas recabe sobre usted. Usted tiene derecho a recibir y revisar la información si así lo solicita. También tiene derecho a pedir que la dependencia estatal corrija cualquier información que se determine que es incorrecta. Consulte el sitio *http://www.dshs.texas.gov* para más información sobre el aviso de confidencialidad. (Fuente: Código gubernamental, secciones 552.021, 552.023, 559.003 y 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
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