



**Primary Medicine Of North Texas**  
**140 W. Lamberth Rd. Suite C**  
**Sherman, Tx 75092**  
**Phone: 903-868-0808**  
**Fax: 903-813-0953**

Dear Patient,

We would like to take an opportunity to thank you for choosing Primary Medicine of North Texas and Dr. Hernandez as your primary care physician. You have a choice of many physicians in our community. The fact that you have chosen us is a great honor. At Primary Medicine of North Texas, we are dedicated to providing our patients with the best possible health care.

Enclosed you will find new patient information and release forms as well as additional information about our practice. Before your scheduled appointment, please carefully read and complete this packet. Once completed, you may return it to the receptionist to be filed in your chart.

All of the information contained in this packet is a component for your health care.

Please complete them fully to the best of your ability.

At the time of your appointment, you will be asked to provide your insurance card (s) as well as photo ID. Your co-payment, coinsurance, deductibles, and any other unpaid balances are due before each appointment. Also keep in mind that we will ask for a copy of your insurance card (s) at each return visit.

If you are unable to keep an appointment for any reason, please contact our office within 24 hours of your scheduled appointment time. There is a \$35.00 charge for any scheduled appointment that you do not keep without canceling.

Our office hours are as follows:

Monday - Thursday: 8:00a.m. - 12:00p.m. and 1:00p.m. - 4:30p.m.

Friday: 8:00a.m. - 12:00p.m.

Again, thank you for choosing Primary Medicine of North Texas. Please feel free to contact us at any time with your questions or concerns.

Sincerely,

Robert J. Hernandez, M.D. and Staff

## **MEDICAL PRIVACY**

Primary Medicine of North Texas is dedicated to protecting your right to privacy of your medical information while providing the highest quality medical care. We want you to be aware of the regulations that affect how we use and disclose your medical information, and the rights that you have regarding your medical records. Privacy rules adopted as part of the federal Health Insurance Portability and Accountability Act (HIPAA) establish standards for the release of medical information that personally identifies you.

### **Our Privacy Practices:**

- We must provide you access to a Privacy Notice that explains how we may use or disclose your medical information.
- We will ask you to acknowledge that you have received and understood our privacy notice.

### **Your Permission:**

Once we have let you know about our privacy practices, we may release information about you for purposes of your treatment, billing for services, or for office operations such as quality assurance without further permission from you. However, you may restrict to whom you want your medical information to be released to and you may revoke your permission to use or disclose your medical information at any time.

### **Your Rights Regarding Your Medical Records:**

The Federal Privacy Regulations give you many rights regarding your medical records.

They include:

- The right to an accounting of certain disclosures of your medical information in the six years prior to the date of your request.
- The right to inspect and obtain a copy of your medical information.
- The right to receive confidential communications of your medical information by alternative means or at an alternative location.
- The right to request an amendment to your medical record.
- The right to submit a complaint to this office about how your medical information is used or disclosed.

**If you have any questions about how this office will use or disclose your medical information or about your rights, please contact:**

**Primary Medicine of North Texas 140 W. Lamberth Rd. Suite C Sherman, Tx 75092  
(903) 868-0808**

**or you may send a written complaint to:**

**U.S. Department of Health and Human Services HIPAA Compliant 7500 Security Blvd., C5-24-04 Baltimore, MD 21244**

**Our Promise To You**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

**Requests to Inspect Protected Health Information**

As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records clerk for Primary Medicine of North Texas. Your first accounting of disclosures (within 12 months) will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list.

If there is a charge, we will notify you and you may choose to withdraw or modify your request **before** any costs are incurred.

**Complaints**

If you are concerned that your privacy rights have been violated, you may contact our office. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

**Contact Information**

For further information concerning your privacy practices please contact:

Primary Medicine Of North Texas  
140 140 W. Lamberth Rd. Suite C  
Sherman, Tx 75092  
Phone: 903-868-0808

U.S. Department of Health and Human Services HIPAA  
Complaint 7500 Security Blvd., C5-24-04 Baltimore, MD  
21244

**Effective Date**

This notice was initially effective April 14, 2003. It remains in effect after revision on or after July 31, 2006.

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA and MasterCard. There is a \$35.00 fee on any NSF check. We may be unable to accept personal checks in the future and reserve the right to collect this amount before further treatment can be provided.

#### **Consent for Services**

I request, authorize and give consent for Primary Medicine of North Texas to provide treatments, services and/or products. I understand that any treatments, services and/or products to be provided will be requested by my physician and will be provided under his direct supervision.

Our office follows the "Physician's Notice of Privacy Practices" dated 4/14/03 (HIPPA Policy).

Initial\_\_\_\_\_

#### **Your Insurance**

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment and any additional percentage due at the time of service.
- Please present your insurance card at **EACH VISIT**. Specifically bring to our attention any changes since your last visit.
- If you have insurance coverage with a plan for which we do not have a prior agreement, the charges for your care and treatment are due at the time of the service. We are not contracted with Unicare and Medicaid at this time.
- In the event that your health plan determines a service to be "not covered", you will be responsible for the negotiated rate of service performed.

#### **Missed Appointments**

In the event you fail to cancel a scheduled appointment at least 24 hours in advance of that appointment time, you will be considered "No Show" and will be billed \$35.00 which will be due upon receipt of a statement from this office. Appointment cards are issued for follow up appointments made in the office. Reminder calls the day before your scheduled appointment are complimentary and do not excuse you from notifying us if the appointment cannot be kept. Please note: If there are 3 or more "No Show" visits, this office will not schedule any additional appointments and will discharge the patient from the practice.

Initial\_\_\_\_\_

#### **Assignment of Benefits**

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment checks directly to Primary Medicine of North Texas, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance and patient balances are due upon receipt of statement.

Initial\_\_\_\_\_

#### **Disability Forms**

There will be a \$15.00 charge for all disability forms filled out by our office. Please note: Due to the nature of our practice, these could take up to a week to complete.

Initial\_\_\_\_\_

**Credit Card Authorization**

In an effort to reduce the amount of paper statements sent out each month our office will keep your credit card information on file. This information will be held until your insurance company has paid their portion and notified our office of the amount you owe. In addition to this amount any remaining balances on your account, including no-show fees, will be charged to your credit card. Co pays are still due at the time of the visit.

\*\*This policy will in no way compromise your ability to question your insurance company's determination of payment or dispute a charge. You can be assured that this information will be held confidential.

Card # \_\_\_\_\_ Master Card / Visa    Expiration Date \_\_\_\_\_  
Name as it appears on card (please print) \_\_\_\_\_  
Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Today's' Date: \_\_\_\_\_

**Patient Information:**

Name: \_\_\_\_\_ Male/Female Birth Date \_\_\_ / \_\_\_ / \_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Insured Information:**

Name: \_\_\_\_\_ Birth Date: \_\_\_ / \_\_\_ / \_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DL# \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Group # \_\_\_\_\_ Member ID# \_\_\_\_\_

Phone # \_\_\_\_\_

**Spouse Information:**

Name: \_\_\_\_\_ Birth Date: \_\_\_ / \_\_\_ / \_\_\_

SSN: \_\_\_ - \_\_\_ - \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_ - \_\_\_ - \_\_\_ Cell Phone: \_\_\_ - \_\_\_ - \_\_\_

Work Phone: \_\_\_ - \_\_\_ - \_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**General Information:**

Pharmacy Name: \_\_\_\_\_

Phone# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Consent for Release of Information**

I, \_\_\_\_\_, hereby authorize:  
(Printed Name of Patient or Legal Guardian/Representative)  
(Company or Individual Name) \_\_\_\_\_  
(Address) \_\_\_\_\_ (City/State/Zip) \_\_\_\_\_  
(Phone/Fax #) \_\_\_\_\_

to disclose/release records concerning \_\_\_\_\_  
(Printed Name of Patient)

to:

Dr. Robert J. Hernandez, M.D.  
Primary Medicine Of North Texas  
140 W. Lamberth Rd. Suite C  
Sherman, Tx 75092  
Phone: 903-868-0808  
Fax: 903-813-0953

for the purpose of:

- \_\_\_ Continuing medical treatment
- \_\_\_ Insurance claim for medical services rendered to patient
- \_\_\_ Civil litigation or administrative proceedings by or for patient
- \_\_\_ Other: (specify)

In order to continue treatment for this patient we specifically need:

- \_\_\_ History & Physical
- \_\_\_ Lab results
- \_\_\_ Progress Notes
- \_\_\_ Other: (specify) \_\_\_\_\_

Dates of Treatment:

The individual authorized to release may include information which may be considered information about communicable or venereal disease which may include, but not limited to, diseases such as Hepatitis, Syphilis and gonorrhea, HTV and AIDS.

I understand that my records are protected under State and Federal confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in the regulation. I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of the signature unless another date is specified. (Specified Date: \_\_\_\_\_)

\_\_\_\_\_  
(Signature of Patient or Legal Guardian/Representative) (Date of Signature)

\_\_\_\_\_  
(Relationship of Legal Guardian/Representative) (Patient DOB & SSN)

**Acknowledgement of Review of Notice Of Privacy Practices**

I have reviewed Primary Medicine of North Texas's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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(Signature of Patient or Personal Representative)

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(Printed Name of Patient or Personal Representative)

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(Description of Personal Representative's Authority)

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(Date Signed)

**Release of Personal Information**

I authorize Primary Medicine of North Texas to release the following personal health information:  
(Please check all that apply)

- Lab Requests / Results
- Medication Information
- Radiology / Diagnostic Results
- Release this information to me only
- Release this information to me or the following family members:

Please specify name and relationship: \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Parent Name \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to Release Information**

I hereby authorize Primary Medicine of North Texas to (1) release information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Initial \_\_\_\_\_

**Robert J. Hernandez, M.D.  
Health History Questionnaire**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female

Have you ever had any of the following problems?

- Abnormal Bleeding \_\_\_\_\_ Asthma/Respiratory Problems \_\_\_\_\_
- Blood Transfusion \_\_\_\_\_ Cancer \_\_\_\_\_
- Convulsions/Epilepsy \_\_\_\_\_ Hepatitis/Liver Disorders \_\_\_\_\_
- Kidney Problems \_\_\_\_\_ Chest Pain \_\_\_\_\_
- HIV/AIDS \_\_\_\_\_ Hearing Impairment \_\_\_\_\_

**\*WOMEN ONLY\***

Age Menstruation Began: \_\_\_\_\_ Date of Last Period: \_\_\_\_\_

Total Pregnancies: \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Last Pap Smear: \_\_\_\_\_

Have you every had:

- Menstrual Pain/Discomfort \_\_\_\_\_ Urinary Tract Infection \_\_\_\_\_
- Breast Mass/Pain \_\_\_\_\_ Hot Flashes/Night Sweats \_\_\_\_\_

**\*MEN ONLY\***

Last Prostate Exam: \_\_\_\_\_

Have you ever had:

- Pain/Burning with Urination \_\_\_\_\_ Blood in Urine \_\_\_\_\_
- Change in Urine Flow \_\_\_\_\_ Kidney/Prostate Infection \_\_\_\_\_
- Penile Discharge \_\_\_\_\_ Testicle Pain/Swelling \_\_\_\_\_

## **Notice of Privacy Practices**

### PRIMARY MEDICINE OF NORTH TEXAS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

#### **Uses and Disclosures**

**Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and title medical condition being treated.

**Health Care Operations:** Your health information may be used as necessary to support the day-to-day activities and management of Primary Medicine of North Texas. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law Enforcement:** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

#### **Additional Uses of Information:**

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please be specific in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

#### **Individual Rights:**

You have certain rights under the federal privacy standards.

#### **These include:**

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

## **NARCOTIC AGREEMENT**

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and Dr. Hernandez comply with all state and federal regulations concerning the prescribing of narcotics and controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. Dr. Hernandez's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/ patient relationship and full agreement and understanding of the risks and benefits of using narcotics to treat pain.

1. **You must use one physician to prescribe and monitor all narcotics and controlled substances.**
2. **You must use one pharmacy to obtain all narcotic prescriptions and controlled substances prescribed by Dr. Hernandez.**

PHARMACY: \_\_\_\_\_

- You should inform Dr. Hernandez of all medications you are taking including herbal remedies, since narcotic medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.
- If you request a refill of your narcotic through your pharmacy and it is denied, you may be required to make an appointment to obtain a new prescription.
- Prescription for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.
- You are responsible for keeping your narcotics or controlled substance in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. If your medications are lost, misplaced, or stolen, Dr. Hernandez will not replace the medications.
- YOU MAY NOT GIVE OR SELL YOUR NARCOTICS OR CONTROLLED substance to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.
- Any evidence of drug hoarding, acquisition of any narcotic medication or controlled substance from any other physicians (which include emergency rooms), controlled dose or reduction, loss of prescription, or failure to follow this agreement WILL result in termination of the doctor/ patient relationship.
- You will fully communicate to Dr. Hernandez to the best of your ability at the initial and all follow-up visits your pain level and functional activity level along with any side effects of the medications. This information allows Dr. Hernandez to adjust your treatment plan accordingly.
- You will communicate fully to Dr. Hernandez to the best of your ability at the initial and all follow-up visits your pain level and functional activity level along with any side effects of the medications. This may result in a change to your treatment plan, including safe discontinuation of your narcotic medications when applicable, or complete termination of the Dr. Hernandez to adjust your treatment plan accordingly.
- You should not use illicit substances, such as cocaine, marijuana, etc. While taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your narcotic medications when applicable, or complete termination of the doctor/ patient relationship.
- The use of alcohol and narcotic medications are contraindicated.
- You agree and understand that Dr. Hernandez reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that Dr. Hernandez may change your treatment plan, including safe discontinuation of your narcotic medication and controlled substance when applicable, or complete termination of the doctor/ patient relationship.
- Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory material on the use of controlled substances to treat pain.

- There are side effects with narcotic therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive ( mental status) and/ or motor ability. Overuse of narcotics can cause decreased respiration (breathing).
- Physical dependence and /or tolerate can occur with the use of narcotics.

Physical dependence and means that if the narcotic medication is abruptly stopped or not taken as directed a withdrawal symptom can occur. This is normal physiological response. The withdrawal syndrome could include but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one’s mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes on or more of the following: impaired control over drug use, compulsive use continued use despite harm, and cravings. This means the drug decreased ones quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drugs effects over time. The dose of the narcotic may have to be titrated up or down to a dose that produces maximum function and a realistic decreased of the patient’s pain.

- If you have history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with narcotics for pain may increase the possibility of relapse.
- You agree to allow Dr. Hernandez to contact any healthcare professional, family member, pharmacy legal authority, or regulatory agency to obtain or provide information about your care or actions if Dr. Hernandez feels it is necessary.
- You agree to a family conference or a conference with a close friend or significant other, if Dr. Hernandez feels it necessary.

The above has been explained to me by \_\_\_\_\_ and I agree to its terms so that Dr. Hernandez can provide quality pain management using narcotic therapy to decrease my pain and increased my function.

Patient’s signature \_\_\_\_\_ Date \_\_\_\_\_

Witness signature \_\_\_\_\_ Date \_\_\_\_\_