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THERESA PEREZ, NP-C

Family
FAMILYPRACTICEASSOCIATES, P.A.
The doctor is in.

* BOARD CERTIFIED BY THE AMERICAN BOARD OF FAMILY PRACTICE

Welcome to Family Practice Associates. We are pleased to have you join our family.
Please carefully review the following information regarding our services:

Office Hours:
Monday-Thursday 8:00 a.m. – 5:00 p.m.
Friday 8:00 a.m. - 5:00 p.m.
Saturday 8:00 a.m. - 12:00 p.m.

Please be advised that our office hours may vary during specific periods throughout the year. The afterhours recording reflects the accurate operating hours at all times. Our office hours may be affected by adverse weather conditions. Please keep our number handy…it is 830-896-4711. Saturday hours are reserved for sick patients who become sick after-hours Friday and are seen on a walk-in basis only. Appointments are not required on Saturdays.

Sick Hours:
Sick appointments are scheduled throughout the day. Same day sick appointments refer to those appointments scheduled on the day of your illness.

Appointment Scheduling:
To schedule an appointment, please call (830) 896-4711. In an effort to provide expedient services to all patients, we ask that if you need to cancel or reschedule an appointment please call our office at least 24 hours ahead of your appointment time. Failure to call the office could result in a $25 no show fee (effective 09/19/2008). Patients arriving 15 or more minutes beyond their scheduled appointment time will be asked to reschedule.

We want to reduce the wait time for all patients…please arrive 10-15 minutes early to insure you are on time for your visit.

Additional Services:
Full range of healthcare services, including adults, children, and women health.

Provide Hospital care.

Lunch hour appointments.

A nurse is a phone call away! During office hours, parents may speak with our triage nurse who provides information on a wide range of medical topics.

For added convenience, use our Prescription Line 896-4711, option 3 & 1.

Insurance Billing questions 830-896-2903.

In preparation for your visit:
For the initial visit, please plan to arrive 30 minutes prior to your appointment time to complete the registration packet. For all other visits, please arrive 15 minutes prior to your appointment time. Also, please, remember to bring your current insurance card with you. To avoid unnecessary out-of-pocket expenses, be sure that our doctors are listed as your primary care physician (PCP).

OUR MISSION

Family Practice Associates, P.A. is dedicated to serve the Hill Country community. Providing quality medical care with compassion to our patients and their families, promoting physical, mental and spiritual well-being.

MEDICAL ARTS PLAZA * 220 WESLEY DRIVE
KERRVILLE, TEXAS 78028
830.896.4711 * FAX 830.257.0878 * FPA-DOCS.COM Revised 3.19.24

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HIPAA NOTICE OF PRIVACY PRACTICE
PATIENT CONSENT/ACKNOWLEDGE FORM

I hereby acknowledge receipt of the Notice of Privacy Practice.

With this consent, Family Practice Associates, P.A. may call and leave a message on voice mail or in person, mail, email to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment, Healthcare Operations, pertaining to my clinical care, including laboratory test results, or items such as appointment reminder cards and patient statements.

I have the right to request that Family Practice Associates, P.A. restrict how it uses or discloses my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Restrictions:
_____

By signing this form, I am consenting to allow Family Practice Associates, P.A. to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment, Healthcare Operations.

Disclose my Protected Health Information (PHI) to:
_____

Family Practice Associates, P.A. may leave a message: **Yes No (circle one)**

Phone #: _____

Phone #: _____

_____
Signature of Patient/Guardian

_____
Print Name of Patient

Date _____

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_____
Patient name

_____
Date of Birth

Rx (Prescription) History Consent

Patient or Authorized Person's consent

I authorize the Provider of Family Practice Associates, P.A. to view my prescription history form other external sources.

With this consent, Family Practice Associates, P.A. Provider(s) may view my prescription history when seen by other providers that have prescribed medications elsewhere to assist the Family Practice provider(s) in carrying out treatment.

Y Yes, I give my consent to view my prescription history

_____
Patient or Authorized Person

_____
Date

N No I do not give my consent to view my prescription history

_____
Patient or Authorized Person

_____
Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Release Medical Records from:

_____
Physician/Facility

_____
Mailing Address

_____
City, State, Zip

Fax: _____

Phone: _____

To Release Medical To:

FAMILY PRACTICE ASSOCIATES
Name of Company/Agency/Person

220 WESLEY DR.
Mailing Address

KERRVILLE, TEXAS 78028
City, State, Zip

Fax**: 830-257-0878**

Phone: **830-896-4711**

*******DO NOT FAX MEDICAL RECORDS*******

Information to be released:

I hereby authorize the above named source to release or disclose: all medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including, but not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), symptomatic HIV infection, and HIV antibody testing.

Reason for release:

City State Zip Phone/Cell

- Moving – new address _____
- Changing Treating Doctors
- Other _____

Please release information via: ☐ Mail ☐ Pick up, phone/cell No. _____

"Medical Records" means information recorded in any form or medium that identifies the patient and relates to the patient's history, diagnosis, treatment or prognosis. Note: Texas law authorizes the release of health care information without patient authorization in a number of situations, including disclosures to a third-party payer such as insurance companies if the disclosure is to reimburse the health care provider, or the patient, for medical services and supplies. This authorization is valid for 90 days from the date of signature, unless I specify otherwise or revoke it.

Patient Information: Name: _____
Social Security #: _____
Date of Birth: _____

_____ _____
Signature of Patient or Auth. Agent Date

_____ Relation to Patient

FAMILY PRACTICE ASSOCIATES, P.A.
220 WESLEY DR
KERRVILLE TX 78028
830-895-4711

webpage: www.fpa-docs.com

HEALTH HISTORY QUESTIONNAIRE
ALL AREAS MUST BE COMPLETED

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): M F	**DOB:**

Marital status: Single Partnered Married Separated Divorced Widowed

Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

BRING ALL PRESCRIBED AND NON-PRESCRIBED MEDICATION IN THE ORIGNAL CONTAINER

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
BRING ALL PRESCRIBED AND NON-PRESCRIBED MEDICATION IN THE ORIGNAL CONTAINER		

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit _____				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

	Are you sexually active?	☐ Yes	☐ No

Sex	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

		AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT HELATH PROBLEMS
Father				Children	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			Grandmother maternal			
	☐ M ☐ F			Grandfather maternal			
	☐ M ☐ F			Grandmother paternal			
	☐ M ☐ F			Grandfather paternall			

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Age at onset of menstruation: _____
Date of last menstruation: _____
Period every _____ days
Heavy periods, irregularity, spotting, pain, or discharge? Yes No

Number of pregnancies _____ Number of live births _____
Are you pregnant or breastfeeding? Yes No
Have you had a D&C, hysterectomy, or Cesarean? Yes No

Any urinary tract, bladder, or kidney infections within the last year? Yes No

Any blood in your urine? Yes No

Any problems with control of urination? Yes No

Any hot flashes or sweating at night? Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge? Yes No

Date of last pap and rectal exam? _____

MEN ONLY

Do you usually get up to urinate during the night? Yes No
If yes, # of time _____

Do you feel pain or burning with urination? Yes No
Any blood in your urine? Yes No
Do you feel burning discharge from penis? Yes No
Has the force of your urination decreased? Yes No
Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No
Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam?

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain

- ___ Skin
- ___ Head/Neck
- ___ Ears
- ___ Nose
- ___ Throat
- ___ Lungs
- ___ Chest/Heart
- ___ Back
- ___ Intestinal
- ___ Bladder
- ___ Bowel
- ___ Circulation

Recent changes in:

- ___ Weight
- ___ Energy level
- ___ Ability to sleep
- ___ Other pain/discomfort

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Family Practice Associates Financial Policy

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Family Practice Associates accepts cash, personal check, Visa, MasterCard and Discover. There is a service charge for returned checks of $30.00.

Patients with an outstanding balance of 60 days overdue must make arrangements of payment prior to scheduling appointments. We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation to set Financial Arrangements, not to exceed 90 days.

Patient with and with out insurance are eligible to receive a discount when applicable. If the patient is under insured or has a high deductable or has no insurance. There will be an automatic 25% discount for patients who are in good standing with the practice, i.e., have a zero balance and pay their current bill in full at the time of service.

The Cashier will collect 20% for all office procedures. The cashier will make the patient aware that their insurance may not cover some care that the patient or FPA health care provider has good reason to think the patient needs. *(Effective; 02/2008)*

Insurance: We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received a payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. We do bill secondary insurance companies as a courtesy to you. Your time-of-service receipt includes all information necessary for submitting claims to your insurance company.

Annual Wellness Visit: Annual wellness visits are intended to review your general health and develop a plan to keep you healthy. If you have specific medical issues, your doctor may choose to treat these at the same time as your wellness visit. These additional services may be charged in addition to the wellness visit, and may be subject to deductible, co-insurance and/or co-pay. If you want to know the cost, ask your doctor before the visit.

If you need assistance or have questions, please contact the Billing department between 8:00 a.m. and 4:30 p.m. Monday through Friday at (830) 896-2903.

Refunds: Overpayments will be refunded upon written request to the responsible party within 30 days of request.

Medicaid: If you are enrolled in a managed care insurance plan, (i.e., Superior, TexasStar, and PCCM), you must receive an administrative referral or Authorization *before* seen **NO** retroactive referrals will be given. If Family Practice Associates or any of our Providers (Dr. John Davis, Dr. David Sprouse, Dr Karsten Tucker, Dr. Hoff, Loretta Keese, PA-C., Jennifer Palmer, NP-C or Thresa Perez, NP-C) is not the primary care provider you will be responsible for your visit.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand Family Practice Associates Financial Policy. I agree to assign insurance benefits to Family Practice Associates whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative: _____

Patient Name: _____**Patient D.O.B.**_____**Date:** _____

How did you hear from us?
Please check one or more: Friend/Family Co-worker _____ Referral _____ Website _____ Television _____ Mail _____

PATIENT NAME_____ SEX_____ AGE_____
Last First Middle

DATE OF BIRTH_____ LANGUAGE_____ RACE_____ HISPANIC NON-HISPANIC
ETHNICITY, PLEASE CIRCLE

SOCIAL SECURITY#_____ Email address: _____

MAILING ADDRESS_____
No. & Street Apt. No. City State Zip Code

HOME PHONE ( ) _____ CELL _____ CELL _____

EMPLOYER_____ WK PH_____
Name & Address

MARITAL STATUS: Single Married Divorced Widowed Minor/Chid

SPOUSE'S NAME_____CELL_____

SPOUSE" S EMPLOYER_____ WK PH _____

MINOR/CHILD ONLY

Father's Name_____
Address_____
Date of Birth_____
Daytime Phone_____
Employer_____ Phone_____

Mother's Name_____
Address_____
Date of Birth_____
Daytime Phone_____
Employer_____ Phone_____

EMERGENCY CONTACT

NAME_____PHONE_____
Last First Middle Int.

ADDRESS_____Relationship_____
City State Zip

REFERRED BY_____ EMAIL _____

Has any family member ever been treated here? No Yes Name_____

INSURANCE

INSURANCE NAME _____ ID # _____GROUP #_____
Must present card at each visit

Subscriber's Name_____ EMAIL _____
Last First Middle Int.

Subscriber's Date of Birth_____ Subscriber's Social Security No._____

Subscriber's Employer_____

Secondary/Insurance Name: _____ ID#._____ Group #_____

THIS CERTIFIES INSURANCE COVERAGE AS LISTED ABOVE AND THAT I HAVE NO OTHER HEALTH INSURANCE COVERAGE_____
Patient or Parent's Signature, as applicable

FINANCIAL AGREEMENT AND AUTHORIZATION FOR PAYMENT:

I authorize the Physicians of Family Practice Associates, P.A. to render medical treatment and emergency medical services, in my absence, to the patient above, and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon receipt thereof.

I authorize the release of any medical information necessary to process the filing of insurance to cover cost of medical treatment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending stat of claims thereon, and proceeds of insurance are assigned to this office where applicable, but without F.P.A. assuming responsibility of the collection thereof. A copy of this assignment is as valid as the original.

SIGNATURE_____ Date: _____
Responsible Party

LOCAL PHARMACY: _____ MAIL IN PHARMACY _____

FAMILY PRACTICE ASSOCIATES, P.A.

ELECTRONIC MAIL INFORMED CONSENT FORM

Many patients prefer the convenience of electronic mail ("e-mail") to other forms of communication. For results only, FPA offers patients the opportunity to communicate by e-mail. FPA will follow the practice's Electronic Mail Policy. As provided in that policy, patients will be required to meet face-to-face with the physician at his/her discretion. The following types of information may be disclosed through e-mail:

- **Normal Test Results Ordered by FPA Providers only:** All "No Reply" e-mails to patients concerning Ancillary Testing will be in the patient record. Since the information will be considered part of the record, other individuals authorized to access the record, such as staff and billing personnel, will also have access to those e-mails. Note that all e-mail is retained in the record of the system sending the e-mail.

- **Disclosures within FPA's Office:** FPA may not forward e-mails internally to other workforce members unless requested by the Provider.

Although FPA acknowledges the conveniences of e-mail to notify patients of normal results, the use of e-mail is for designated staff to notify patient of normal test results only. Information by e-mail has a number of risks that you should seriously consider prior to using e-mail. These risks include, but are not limited to, the following:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcasted worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily send an e-mail to the wrong address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

Taking into account these risks, FPA will use reasonable means to protect the security and confidentiality of e-mail communications as required by HIPAA, HITECH and Texas Law. However, it is impossible for FPA to guarantee the security and confidentiality of e-mail communications.

Should confidential information be improperly disclosed, through no fault of FPA, FPA will not be liable for such disclosures.

E-MAIL SHOULD NOT BE USED FOR MEDICAL EMERGENCIES.

No Reply e-mail communication for normal test results will be sent to patients. FPA cannot guarantee that any particular e-mail will be read by the patient within any particular period of time. Therefore, should you need immediate assistance, please call FPA at 830-896-4711 to notify our office.

FAMILY PRACTICE ASSOCIATES, P.A.

By consenting to receiving normal ancillary FPA test results through e-mail, you also agree to the following responsibilities:

- It is your responsibility to schedule appointments.
- You should NOT use e-mail in order to make disclosures about sensitive medical information such as:
  a. Substance Abuse
  b. AIDS/HIV
- It is your responsibility to inform FPA of any changes to your e-mail address.

If we chose not to comply, we will not communicate with you via e-mail.

Should you wish to revoke this consent, revocation must be made in written form. The revocation must be addressed to ***Medical Secretary***, who may be contacted at the following phone number: 830-896-4711.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT:

I acknowledge that I have read and fully understand this consent form.

I understand the risks associated with the communication of e-mail as set forth in this consent form.

Despite the risks associated with e-mail, I agree that my FPA and his/her workforce may use e-mail to facilitate communications to or about me. I understand that disclosures regarding my treatment and diagnosis may be made to not only me, but also internally within FPA or to appropriate third parties for services such as billing.

Patient Signature:_____

Date:_____

Witness:_____

Date:_____

Please understand this is a "No Reply" e-mail communication from FPA

Family Practice Associates, P.A. Notice of Privacy Practices

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

This NOTICE applies to **Family Practice Associates (FPA)** and any physician while he or she provides treatment to you at FPA. FPA will share your health information as necessary to carry out treatment, payment, or health care operations. We are required by law to maintain the privacy of **Protected Health Information (PHI)** and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information (PHI), and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

"**P**rotected **H**ealth **I**nformation" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information (PHI).

We may use and disclose your Protected Health Information in the following circumstances:

For Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

For Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

For Health Care Operations. FPA may use and disclose PHI for our health care operations. For example, we may disclose your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Business Associates. FPA may disclose PHI to one of our business associates who perform certain functions and services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI and these contracts prohibit them from using or disclosing the PHI other than treatment, payment, or healthcare operations.

Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

As required by law. FPA will use or disclose medical information about you when required to do so by applicable state or federal law.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get

an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Abuse, Neglect, or Domestic Violence. We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Research. FPA does not use and disclose your PHI for research purposes.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. We will only disclose the information to someone who may be able to help prevent the threat.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military Activity and National Security/Military and Veterans. If you are a member of the armed forces, or you are involved with military, national security or intelligence activities, or if you are in law enforcement custody, we may disclose PHI as required by military command authorities or authorized officials so they may carry out their legal duties under the law. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners, Medical Examiners, and Funeral Directors. We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising Activities. FPA does not use or disclose your PHI, for fundraising activities. If you receive any fundraising communications with our Family Practice Associates name or logo please notify the FPA Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of PHI for marketing purposes; and
3. Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family

members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your PHI, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your PHI, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Foreign Language Version

If you have difficulty reading or understanding English, you may request a copy of this Notice in Spanish.

Riesgo para la salud: Autoevaluación del Paciente

Nombre: _____ Fecha: _____

Edad_____ Género_____ Etnia / Raza _____

Altura_____ Peso_____ IMC_____

Presión arterial_____ Glucosa en sangre_____

Colesterol: Total_____ HDL_____ LDL_____ Trig_____

HISTORIAL MÉDICO:

1. ¿Alguna vez le han dicho que tiene presión arterial alta? **Sí** **No**

2. ¿Le han dicho alguna vez que tiene diabetes? **Sí** **No**

3. Si tiene diabetes, ¿cuál fue su último nivel de hemoglobina A1c? (Encierre en un círculo su respuesta)

Menos de 6 **6 a 6.9** **7 a 7.9** **8 a 8.9** **9 o más** **No estoy Seguro**

ACTIVIDAD FÍSICA / EJERCICIO:

1. ¿Cuántos días / semanas hace ejercicio? _____ ¿Cuántos minutos por día? _____

2. ¿Cómo calificaría la intensidad de su ejercicio? (Marque uno): **Sin ejercicio**

Ligero	**Moderado**	**Extenuante**	**Muy extenuante**
(estirarse, caminar lento)	**(caminar rápido)**	**(trotar / nadar)**	**(correr rápido / subir escaleras)**

USO DE FUMAR / TABACO: (Círculo de respuestas)

1. ¿Fuma actualmente cigarrillos u otros tipos de tabaco? **Sí** **No**

2. ¿Es usted un exfumador? **Sí, pero dejé** **No, nunca fumé**

3. Si dejó de fumar, ¿cuánto tiempo ha pasado desde que dejó de fumar cigarrillos?

<6 meses **6-11meses** **1-5 años** **6-10 años** **> 10 años atrás** **N / A**

4. ¿Utiliza actualmente alguno de estos otros productos de tabaco? Si es así, circule debajo

Puros **Pipas** **Tabaco de mascar /rapé** **No uso ningún otro producto de tabaco**

USO DE ALCOHOL:

1. En una semana típica, ¿cuántos días bebe alcohol? _____ días / semana

2. Los días que bebe alcohol, ¿cuántas bebidas consume en promedio? _____bebidas

3. En una semana típica, ¿con qué frecuencia toma 5 o más tragos en una ocasión? (Un círculo)

Nunca **una vez a la semana** **2-3 veces a la semana** **> 3 veces a la semana**

NUTRICIÓN:

1. ¿Cuántas porciones totales de frutas y verduras suele comer al día? _____

2. ¿Cuántas porciones de alimentos con alto contenido de fibra o cereales integrales consume al día? _____(1 porción = 1 rebanada de pan 100% integral, 1 taza de cereal integral, ½ taza de avena)

3. ¿Cuántas porciones de alimentos fritos o con alto contenido de grasa consume al día? _____ (1 porción = 1 rebanada de tocino, 15 papas fritas, 1 rosquilla, 1 cucharada de aderezo cremoso para ensaladas, 1 taza de leche entera)

SEGURIDAD DEL VEHÍCULO DE MOTOR:

1. ¿Siempre usa el cinturón de seguridad cuando está en el automóvil? **Sí** **No**

2. ¿Alguna vez maneja después de beber o viaja con un conductor que ha estado bebiendo? **Sí** **No**

EXPOSICIÓN AL SOL:

1. ¿Se protege del sol cuando está al aire libre? **Sí** **No**

PSICOSOCIAL, ESTRÉS Y BIENESTAR: (Encierre en un círculo una respuesta por pregunta)

1. Durante las últimas 2 semanas, ¿con qué frecuencia se ha sentido deprimido, deprimido o sin esperanza?

Todo el tiempo **La mayor parte del tiempo** **Algunas veces** **Casi nunca**

2. Durante las últimas 2 semanas, ¿con qué frecuencia ha sentido poco interés o placer en hacer cosas?

Todo el tiempo **La mayor parte del tiempo** **Algunas veces** **Casi nunca**

3. ¿Sus sentimientos le han causado una angustia significativa o han interferido con su capacidad para interactuar socialmente? **Sí** **No**

4. Durante los últimos 6 meses, ¿con qué frecuencia se ha sentido triste o deprimido?

Todo el tiempo **La mayor parte del tiempo** **Algunas veces** **Casi nunca**

5. ¿Con qué frecuencia el estrés es un problema para usted?

Todo el tiempo **La mayor parte del tiempo** **Algunas veces** **Casi nunca**

6. ¿Qué tan bien maneja el estrés en su vida?

Pobre **Regular** **Bueno** **Muy bien**

7. En general, ¿cómo calificaría su salud?

Pobre **Regular** **Bueno** **Muy bien**

8. ¿Con qué frecuencia obtiene el apoyo social y emocional que necesita?

Casi nunca **Algunas veces** **La mayor parte del tiempo T** **Todo el tiempo**

9. En general, ¿qué tan satisfecho está con su vida?

Muy insatisfecho **Insatisfecho** **Satisfecho** **Muy satisfecho**

10. ¿Cuántas horas de sueño sueles dormir cada noche? _____