Pampa Medical Group

Office Policies

Making an Appointment

Request an appointment: call our office to schedule your next visit.

- If it's been a year since your last check-up, call for a complete preventive care exam. Children should be scheduled for periodic well-child exams to monitor their growth and development and keep up with their immunizations.
- If you need to schedule allergy shots, blood draws, or blood pressure checks, please contact the office for the best available times.
- Disease management is one of our most important ways of keeping you healthy. For our patients with diabetes, asthma, high blood pressure, and heart disease, regularly scheduled visits are very important.
- If you have made the appointment for yourself, please don't ask us to see another family member or friend during your appointment time. We would be happy to schedule an appointment for them at another time.
- If your address, phone number, or insurance has changed, please let us know while scheduling your appointment so that we can have the most up-to-date record for you.

When You Arrive

Please check in and update your information.

- Plan to arrive 15 min before your appointment time to complete your registration and insurance information.
- When you first arrive, please register with the receptionist.
- Please bring your insurance cards and a valid photo ID to your appointment.
- Self-pay patients (those with no insurance); please be prepared to pay for your visit at the time of service.
- Please be courteous. We ask that you do not bring food or drinks into the waiting room. Once you are in the exam room, please turn off your cell phone.

When You Are Late For an Appointment

Your time is valuable - and so is the doctor's

- Please be prompt.
- If you arrive after your scheduled appointment time, your appointment may need to be rescheduled.

Cancelling Your Appointment

Please give us 24 hours advanced notice.

- Please call us as soon as you know you won't be able to make your appointment. Calling the day before will help us to make that appointment available to someone who may need urgent or sick care.
- If you are a new or established patient and you do not show up for 2 consecutive appointments, and you do not call to cancel, we will consider that a termination from the practice.

When You Need Us After Hours

- When you call our office after hours, you will be directed to our answering service. The representative will take your call and forward your message to the on-call provider.
- If you are experiencing a medical emergency or you believe you are experiencing a life threatening situation, call 911 immediately, or go to the emergency department of your nearest hospital.
- If your urgent medical need is not life threatening, and it is during normal business hours, please call the office. We will help you determine the best plan of care.

Your Results for Diagnostic Testing

We know that you want to know the results of your lab tests and other diagnostic testing as soon as you can.

- When test results are returned to the office, they are first reviewed by your doctor or provider. As soon as they are available, our nursing staff will notify you of your results either by phone or by letter. Please do not call to request test results before two weeks have passed.
- You may be asked to call the office and make a follow-up appointment with your doctor to discuss the test results and follow-up plan, if necessary.

Refilling Your Prescription

- When you need a general prescription filled, contact your pharmacy. The pharmacy will notify your provider through a secure electronic prescription refill system called E-Rx. Check with your pharmacy to see if they participate in the E-Rx system. If they don't, your provider will provide you with hard copies of your prescription to bring to your pharmacy.
- Please allow at least 48 hours for all prescription refill requests.
- If you need a refill for a controlled medication, an appointment may be required.

Referrals for Specialty Care

- When it comes to referrals, there are many things to consider- your doctor's special orders, whether the specialist participates with your insurance company, and getting an appointment scheduled as soon as possible. Please allow time for the staff to get the appropriate referral done.
- Please communicate with your provider regarding any specialists you are seeing. This will ensure that the appropriate referrals are done, and will keep your primary care doctor in the loop.

When You Need a Form Filled Out

We are happy to help you when we have advance notice.

- We are happy to accept medically related forms that require your doctor's signature.
- First, fill out all of the information about the patient, like your name, address, date of birth, social security number, and employer. Make sure to sign your name if the form requires it.
- Then give the form to the receptionists at the front desk. They will forward your form to the forms nurse, who will then route it to your provider.
- We cannot complete forms for pick up on the same day. We will call you when the form is ready, within 7 to 10 business days.

Sending Your Records to Another Doctor

You may request a copy of your medical record.

- Sometimes, our patients will need a copy of their medical record in order to transfer to another doctor. A records release form must be filled out in order for our records department to transfer your records to another doctor.
- Our patients may request a copy of their medical record for themselves, an insurance application or legal representation. The patient, insurer, or legal counsel will be billed at $25.00.

Paying Your Bill

- Payment for your visit is due at the time of service. You may have a co-pay, co-insurance, or deductible that will be due at the time of your visit.
- Our knowledgeable and experienced billing department is ready to help you with payment and insurance related questions. They are available Monday through Friday, 8:00am until 4:30pm.
- If your account has been turned over for collection, balance in full will be expected prior to next visit.

Patient Termination Policy

- Although it is an infrequent occurrence, a patient/physician relationship may be terminated. Common reasons for termination include, but are not limited to, use of foul language, chronic noncompliance with recommended therapy, abusive behavior to staff, physicians, visitors or other patients, or other disruptive behavior. Recommendation of termination by any Pampa Medical Group provider could exclude the patient from seeing any other provider in the group.

PAMPA MEDICAL GROUP
NEW PATIENT QUESTIONNAIRE

Name: _____ D.O.B. _____

Address: _____

Home Phone: _____ Cell: _____

Health Insurance: _____

Name of last Primary Care Doctor: _____

Reason for change: _____

Date of last visit with your last primary care provider: _____

Please list any medical conditions:

_____

_____

_____

Please list all medications you currently take along with date last filled and prescribing physician:

_____

_____

_____

**Please use back of form if needed

Tobacco use: Yes _____ No _____

Type: _____ Number of Years: _____

Usage per Day: _____

PAMPA
MEDICAL GROUP

Primary Care Physician _____

Date_____ Pharmacy_____ Reason for Visit___ _____

PATIENT
NAME _____
Last First Middle Initial DATE OF BIRTH

MAILING ADDRESS_____
Street Address City State Zip

Phone _____ _____ _____ Marital Status_____
Home Cell Work

SOCIAL SECURITY #_____EMPLOYER_____

Male_____ Female____RACE_____ PREFERRED LANGUAGE_____

RESPONSIBLE PARTY:

NAME _____Relationship to Pt_____
Last First Middle Initial Date of Birth

ADDRESS_____
Street City State Zip

Phone _____ _____ _____ Marital Status_____
Home Cell Work

SOCIAL SECURITY #_____EMPLOYER_____

EMERGENCY CONTACT_____
(NOT IN HOUSEHOLD) Name Phone : Relationship to Patient

INSURANCE
PRIMARY _____SECONDARY_____

****PLEASE GIVE RECEPTIONIST COPY OF INSURANCE CARD***

CLINIC POLICY

All Professional Services Rendered are charged to the patient. Necessary Forms will be completed to help expedite Insurance Carrier Payments however the patient is responsible for all fees regardless of insurance coverage.
All payments will be due at time of service unless arrangements are made in advance.
Patients with no insurance will be expected to pay at the time of service.
We accept Cash, Checks and Major Credit Cards

PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of an original.
I authorize Pampa Medical Group to apply for benefits on my behalf for services rendered by them or by this order. I request payment from my insurance be paid directly to Pampa Medical Group.
I certify that the information I have reported with regard to my insurance coverage is correct and I will pay any unpaid balance by my insurance company 10 days after receiving a bill from Pampa Medical Group.

Pampa Medical Group may leave messages on my Home Phone _____Yes _____NO Work Phone_____Yes _____NO

Signature of
PT/Parent/Guardian_____Date_____

PAMPA MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

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.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At our facility privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your informationwith care. Our employees access information about you when necessary to provide treatment, verify eligibility and obtain authorization about you when considering a request from you when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principals.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address, and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Also, in order to remind you of appointments or changes in appointments we may leave a message with someone in your household or answering machine either at home or place of employment. From time to time, we may send information via USMail regarding appointments, follow-up, or other health information.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please contact the office manager at this clinic. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How-and-why information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within our organization.* We share information wihin our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.To help us offer you more services, we may share information with companies that work for us, such as claim processing and mailing companies that deliver health education and information directly to you. These companies act on our behalf and are obligated to keep the information that we provide them confidential.*

PAMPA MEDICAL GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of this practice's Notice of Privacy Practices. This Notice describes how this practice may use and disclose my information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signatureof Patient,or Personal Representative) (Date)

_____

(Relationship to Patient)

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY MEMBER OR OTHERS

I, _____hereby Authorize Pampa Medical Group to release information regarding my health, care and treatment to the following individuals.

NAME RELATIONSHIP

_____

_____

_____

_____

_____

PATIENT SIGNATURE DATE

PATIENT PORTAL AUTHORIZATION ON THE WEB

Pampa Medical Group offers the opportunity to use the power of the web to track most important aspects of your healthcare through our office. The Patient Portal enables patients to communicate with our staff easily, safely and securely via the internet.

Patients are sent, via email, a secure User ID and Password, enabling them to access our secure Patient Portal to view their health records, including lab and diagnostic test results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal.

In order to provide you access to the Patient Portal, please provide us your email address or select one of the boxes below:

EMAIL ADDRESS:_____

_____I do not have an email address

_____I do not want access to the Patient Portal

_____I do not want to share my email address

Other _____

Advanced Practice Nurse and Physician Assistant - Consent For Treatment

This facility has on staff an advanced practice nurse and/ or physician assistant.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse or physician assistant for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse or physician assistant and request to see a physician.

NAME:_____ DATE:_____

SIGNATURE:_____WITNESS: (optional)_____

CONSENT TO TREAT A MINOR

Any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

You may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name _____
Last Name, First Name, Middle Name

Date of Birth: _____

For occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for: _____ days only, or
_____ (initial here) indefinitely, until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent or legal guardian must be in attendance.
It is the policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____
Parent or Legal Guardian Signature Relationship to Patient

_____
Date

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth / / **Children under 18 years only.*

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

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

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

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

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

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

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

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

Parent, legal guardian or managing conservator:

Printed Name

Date

Signature

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

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 ◦ (512) 776-7284 ◦ Fax: (866) 624-0180 ◦ www.ImmTrac.com
Texas Department of State Health Services ◦ ImmTrac Group – MC 1946 ◦ P.O. Box 149347 ◦ Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.

PAMPA MEDICAL GROUP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I_____ who resides at _____
in the city of _____in the state of_____ hereby authorize:

Name of Doctor: _____
Address: _____
Phone: _____ Fax: _____

to disclose the following specific medical information by mail, fax, or pick-up to:

Pampa Medical Group
3023 Perryton Parkway, Suite 101
Pampa, Texas 79065
Phone: 806-665-0801 Fax: 806-669-1491

from the Health Records of:

Name: _____ Date of Birth: _____
Address: _____
City, St, Zip: _____
Phone: _____

My authorization extends only to those data elements/documents initialed below:

____ Complete Record	____Billing Records	____Progress Notes
____History and Physical	____Radiology Reports	____Radiology Films
____Consultation Reports	____Physicians Orders	____Laboratory Reports
____Record of visit for specific date or dates: _____		____Mental Health Records
____AIDS (Acquired Immunodeficiency Syndrome) or HIV information		____Hepatitis Information
____Other (Must be specific) _____		

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior authorization, except otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original
3. I may revoke this authorization at any time, except where information had already been released, This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available upon request.
4. Pampa Medical Group of Pampa, its employees, officers, and physicians are hereby released from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient or authorized Representative and Relationship Date

_____

Printed Name