

Campbell Clinic

A Service of the Parker County Hospital District

“Welcome”

We would like to welcome you to Campbell Clinic. We are so pleased you have entrusted us with your health care. Our patients, “you” are our priority.

Campbell Clinic is licensed as a Family Practice Rural Health Clinic providing care to patients ages two months and older. As a Rural Health Clinic, our office utilizes Physician Assistants as well as Physicians to provide primary care to our patients. Below is additional information regarding clinic policies and how to best obtain care when needed.

1. Campbell Clinic provides services Monday through Friday from 8:00 am to 5:00 pm. We are closed for lunch from 12:00-1:10. Our telephone number is 817-458-3300.
2. If you are unable to keep an appointment you have scheduled, we ask that you kindly give us 24 hours notice. Any appointment cancelled on the same day without legitimate reasoning will be considered a no show. After two missed appointments you will receive a letter from our office. If you miss three appointments with our office, you may be terminated from our practice. If you are more than 15 minutes late for your appointment you may be asked to reschedule for another day.
3. Prescription refill requests should be directed to your pharmacy. You should contact your pharmacy even if you have zero refills remaining on your medication. We suggest notifying your pharmacy 2-3 days before running out of medication. We have 72 hours to respond to all refill requests. Please remember all requests received over the weekend or after hours will not be addressed until the following work day.

4. If you have a medical emergency and need to discuss your care with a provider/physician after hours, you may contact the provider on call. The on call provider may be reached by dialing the main number. Please note this service is not for prescription refills, general medical advice or routine care. To discuss any of these issues please contact the office during normal business hours. Patients who abuse this system may be terminated from the practice.

Once again we would like to welcome you to Campbell Clinic. If you have additional questions regarding this form, ask any staff member and we will be happy to assist you.

Patient Signature

Date

Campbell Clinic

Patient Rights and Responsibilities

Patient Rights

Access to Care

The patient has the right to impartial access to treatment or accommodations. The patient has the right to seek a second opinion and/or a consult with a specialist.

Information

The patient has the right to complete and current information concerning diagnosis, treatment, and any known prognosis. The patient also has the right to know the identity and professional status of individuals providing service.

Informed Consent

Before giving consent for any treatment, the patient has the right to receive information regarding treatment options, risks and benefits of options, possible side effects, costs, whether care is part of research and who is providing their care. The patient has the right to accept or refuse any treatment.

Pain Management

The patient has the right to appropriate pain management.

Patient Concerns/Complaints

The patient has the right to express concerns, dissatisfactions or complaints without care being compromised by contacting the Office Manager.

Personal Safety

The patient has the right to expect reasonable safety where Campbell Clinic practices and environment are concerned.

Privacy and Confidentiality

The patient has the right to personal and informational privacy.

Respect and Dignity

The patient has the right to considerate and respectful care at all times.

Patient Responsibilities

Respect and Consideration

The patient is responsible for being considerate of the rights of other patients and clinic employees. The patient is responsible for being respectful of the property of other persons and of Campbell Clinic.

Compliance

The patient is responsible for providing accurate health information, following the treatment plan, and asking questions when something is not clear.

Fulfilling Obligations

The patient is responsible to pay for financial obligations as promptly as possible.

Refusing Treatment

The patient is responsible for personal consequences if they refuse or fail to follow the practitioner's instructions.

**Campbell Clinic
1517 Texas Drive
Weatherford, TX 76086
817-458-3300**

HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I have had the opportunity to read and ask questions regarding this policy.

Patient/Guardian Signature _____ Date _____

HIPAA Notice of Privacy Practices

**Campbell Clinic
1517 Texas Drive
Weatherford, Tx 76086
817-458-3300**

**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**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information: is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians’ practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health payer to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us on request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect of their protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the Parker County Hospital District, 817-599-1225

Campbell Clinic

Medication Refill Policy

In regards to prescription refills; the following policy applies:

- All patients must contact their pharmacy for refills of prescription medication
- **Please allow 48-72 hours for your refills to be called or faxed back to your pharmacy.
- There will be no refills after hours or on weekends
- Any triplicate medication must be picked up in person. If the patient designates an authorized person to pick up medications, they must present a valid ID and written or oral and verifiable authorization from the patient.
- Should you require 90 day prescriptions for mail order, please contact the office. The following information must be given: patient name, date of birth, medication requested with dosage and strength, and the quantity.
- You are more than welcome to call and see if the prescription refill has been received from the pharmacy. However, we ask that you do not make repeated calls to the office to check on your prescription. Please note **above.

All providers are not in the office everyday of the week.

We appreciate your understanding of our refill policy

Patient Signature

Date

Campbell Clinic Patient Registration

Welcome to our office. In order to serve you properly, we will need the following information.
All information given will be confidential.

| | | | | | |
|-------------------|-----------------------------|--|--|-------------|----------------------------|
| Patient's Name | Sex M F | Date of Birth ___/___/___ Age _____ | Marital Status Single () Married () Widowed () Divorced () | | |
| Residence Address | City | State | Zip | Home Phone: | Patients Social Security # |
| Emergency Contact | | | | | |

Consent for Treatment

I, (we) the undersigned, hereby consent to and authorize the performance of all tests, treatments, procedures and to the administration of all medication and anesthetics which in the judgment of my provider may be considered necessary or advisable. I (we) fully understand that the provider may be a PA (Physician's Assistant) and as such, is qualified to diagnosis, treat and prescribe medications under the direction of the supervising physician. The undersigned, having read and expressed understanding of this document by the signature below, does hereby agree to be medically treated at Campbell Clinic.

Signature _____
Date

Authorization for Release of Medical Information

I authorize my medical information to be released to the following:

| Name | Relationship | Phone | Date Added | Date Removed |
|-------|--------------|-------|------------|--------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Which Pharmacy do you use most often? _____
Have you been to the Emergency Room since your last visit? _____

If the clinic staff needed to reach you regarding appointments, lab results, etc. and was unable to do so, could we leave a detailed message on your answering machine or voicemail?
Yes _____ No _____

Cell phone #: _____ Home Phone #: _____

Campbell Clinic

Patient Name: _____

Consent for Treatment

I, (we) the undersigned, hereby consent to and authorize the performance of all tests, treatments, procedures and to the administration of all medications and anesthetics which in the judgment of my provider may be considered necessary or advisable. The undersigned, having read and expressed understanding of this document by the signature below, does hereby agree to be medically treated at Campbell Clinic.

Signature

Date

Witness Signature

Date

Authorization of Medical Treatment for a Minor

In the absence of a parent or legal guardian the following person(s) has the authority to authorize medical care for the above noted minor.

| Name | Relationship | Phone | Date Added | Date Removed |
|-------|--------------|-------|------------|--------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Authorization for Release of Medical Information

I authorize my medical information to be released to the following:

| Name | Relationship | Phone | Date Added | Date Removed |
|-------|--------------|-------|------------|--------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Campbell Clinic

Review of Systems

Patient Name _____ Date ____/____/____

Do you now or have you ever had any problems related to the following systems circle (Y) for Yes or (N) for No

| | | |
|--|--|--|
| <p>Constitutional Symptoms</p> <p>Fever/Chills Y N</p> <p>Headaches Y N</p> <p>Weight Loss Y N</p> <p>Weight Gain Y N</p> <p>Other: _____</p> <p>Eyes</p> <p>Double vision Y N</p> <p>Blurred vision Y N</p> <p>Pain Y N</p> <p>Glaucoma Y N</p> <p>Cataracts Y N</p> <p>Other: _____</p> <p>Ears/Nose/ Mouth/Throat</p> <p>Hearing changes Y N</p> <p>Nosebleeds Y N</p> <p>Pain swallowing Y N</p> <p>Other: _____</p> <p>Respiratory</p> <p>Shortness of breath Y N</p> <p>Cough Y N</p> <p>Wheezing Y N</p> <p>Other: _____</p> <p>Cardiovascular</p> <p>Chest pain Y N</p> <p>Palpitations Y N</p> <p>High blood press. Y N</p> <p>Other: _____</p> <p>Gastrointestinal</p> <p>Abdominal pain Y N</p> <p>Nausea/Vomiting Y N</p> <p>Indigest/Heartburn Y N</p> | <p>Other: _____</p> <p>Genitourinary</p> <p>Painful Urination Y N</p> <p>Loss of Urine Y N</p> <p>Frequency/Slow Stream Y N</p> <p>Urinary urgency Y N</p> <p>Incontinence Y N</p> <p>Other: _____</p> <p>Neurological</p> <p>Tremors Y N</p> <p>Dizzy Spells Y N</p> <p>Numbness Y N</p> <p>Tingling Y N</p> <p>Other: _____</p> <p>Male</p> <p>Erection Problems Y N</p> <p>Testicular Masses Y N</p> <p>Pain Y N</p> <p>Other: _____</p> <p>Female</p> <p>G ____ P ____ AB ____</p> <p>Dura ____ Birth Cont. ____</p> <p>Age onset Menses ____ Flow ____</p> <p>HRT _____</p> <p>Reg/Irreg ____ Cramps Y N</p> <p>Other: _____</p> <p>Sexual History</p> <p>Sexually active Y N</p> <p>Sexually satisfied Y N</p> <p>Sexual trauma/HIV/STDs Y N</p> <p>Other: _____</p> | <p>Hematological/ Lymphatic</p> <p>Blood clotting prob Y N</p> <p>Blood transfusions Y N</p> <p>Swollen glands Y N</p> <p>Other: _____</p> <p>Endocrine</p> <p>Excessive thirst Y N</p> <p>Too hot/cold Y N</p> <p>Tired/sluggish Y N</p> <p>Other: _____</p> <p>Interaugmentary</p> <p>Rashes Y N</p> <p>Itching Y N</p> <p>Recurrent Infection Y N</p> <p>Other: _____</p> <p>Musculoskeletal</p> <p>Joint pain Y N</p> <p>Neck pain Y N</p> <p>Back pain Y N</p> <p>Other: _____</p> <p>Psychological</p> <p>Are you generally satisfied with your life? Y N</p> <p>Do you experience anxiety depression? Y N</p> <p>Attempted Suicide? Y N</p> <p>Other: _____</p> |
|--|--|--|

Physician/Provider Signature: _____ Date: _____

Physicians use only: (Comments/Notes)