AMARILLO
HEADACHE CLINIC
APRIL HUNLEY NP

Patient Information:

Full Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____State: _____ Zip: _____ Work Phone: _____Ext: _____

Date of Birth: _____ Gender: M F Social Security #: _____

Marital Status: Married Single Divorced Widowed Email: _____

Primary Care: _____ Referring Provider: _____

Employer: _____

Address: _____ City: _____State: _____ Zip: _____

Preferred Pharmacy: _____

Responsible Party Information:

Full Name: _____ Relationship to Patient: _____

Address: _____ Home / Cell Phone: _____

City: _____State: _____ Zip: _____ Work Phone: _____Ext: _____

Date of Birth: _____ Gender: M F Social Security #: _____

Insurance (Primary) NAME: _____

Policy Holder Name: _____

Policy Holder Birth Date: _____

Policy Holder Phone #: _____

Policy Holder SS#: _____

Relationship to Patient: _____

Insurance (Secondary) NAME: _____

Policy Holder Name: _____

Policy Holder Birth date: _____

Policy Holder Phone #: _____

Policy Holder SS#: _____

Relationship to Patient: _____

Reason for your Visit Today: _____

_____

_____

Patient Portal Authorization on the Web

Amarillo Headache Clinic offers the opportunity to use the power of the web to track the 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 in office lab 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 to share my email address
☐ I do not want t access the Patient Portal
☐ Other: _____

Consent for Medical Treatment

I voluntarily present to Amarillo Headache Clinic and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatment or examinations and I understand that all medical treatments contain inherent risks.

_____ _____

Patient or Authorized Person's Signature Date

_____

Patient's Printed Name

Patient's Consent to Obtain External Prescription History

I grant permission to the healthcare providers at Amarillo Headache Clinic, to view my prescription history from other external sources (other pharmacies and/or providers). I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back several years.

_____ _____

Patient or Authorized Person's Signature Date

_____

Patient's Printed Name

FINANCIAL POLICY

AMARILLO HEADACHE CLINIC

Welcome to Amarillo Headache Clinic! We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for several networks and Medicare Part B. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. **Therefore, it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list *before* making an appointment.** You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan.

For non-contracted plans, you will need to pay in full and file your own claim.

YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

CO-PAYMENTS

We require your co-payment at check-in. We will verify insurance and collect payment based on the information provided by your insurance company.

DEDUCTIBLE AND COINSURANCE

If you have a deductible, we will verify insurance and collect payment based on the information provided by your insurance company. We collect deductible, co-insurance and any balance owing at each visit.

REFERRALS, PRECERTIFICATION, AND PRE-AUTHORIZATIONS

Referrals, precertification, and pre-authorization of additional medical services is an area in which we strive to help you. Due to the varying policy provisions of all of our patients plans, it is impossible for us to know each patients specific plan provisions. **If you fail to disclose precertification requirements PRIOR to services being rendered, you may be responsible for payment of all related fees in full.**

***** IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN FOR X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES *****

SECONDARY INSURANCE

We will file secondary insurance as a courtesy to you. Please keep in mind that payment of your account is ultimately your responsibility. We will look to you for payment, if we are unsuccessful in obtaining reimbursement by your insurance.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Amarillo Headache Clinic to become involved in medical bill payment disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed. You may contact our office for a copy of HCFA.

WORKER'S COMPENSATION CLAIMS

We do not participate in Worker's Compensation and are unable to file claims on your behalf. We do not see patients for any work related injuries.

BILLING OF ACCOUNT BALANCES

You will receive a statement for which payment is due upon receipt.

NSF CHECKS

Checks returned for NSF, will have a $35.00 fee added.

NON-PAYMENT OF ACCOUNTS

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

CONSULTATION WITH YOUR OWN ATTORNEY:

AGREEMENT AS TO GOVERNING LAW AND FORUM: The patient and health care provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by the Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas District Court in the county where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state or in any Federal Court. The choice of law and forum selection provisions of this paragraph is mandatory and is not permissive.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Amarillo Headache Clinic.

_____

Signature of Patient or Legal Guardian Date

ASSIGNMENT OF BENEFITS

The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to Amarillo Headache Clinic office provider who rendered services on their Behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.

_____

Signature of Patient or Legal Guardian Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for the physician or staff of Amarillo Headache Clinic to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third-party payers and their agents.

If you wish for a family member or other representative to have access to your information, please list their names below:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I authorize Amarillo Headache clinic to release all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care as well as discuss financial information with the individuals listed above.

_____ I DO NOT authorize Amarillo Headache Clinic to release any information concerning my care to any individual

Signature of Patient or Parent/Guardian _____ Date _____

RECEIPT OF HIPPA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Practices with detailed information about how Amarillo Headache Clinic may use and disclosure my medical information as set forth herein, prior to any service being provided to me.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at Amarillo Headache Clinic and their staff, agents or another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow-up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screening (including the presence of drugs, alcohol, or marijuana).
3. INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected and that I could be held liable for the full cost of services provided Amarillo Headache Clinic. I understand that this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

_____ _____

Signature of Patient or Parent/Guardian Date

AMARILLO HEADACHE CLINIC
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
EFFECTIVE 10-16-2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Amarillo Headache Clinic including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. Our clinic also utilizes e-mail addresses as supplied by you to notify you of appointment information and/or your personal health information.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender

and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. **Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. **Psychotherapy Notes, Marketing and Sale of Medical Information.** Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. **Right to Revoke Authorization**. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. **Right to Inspect and Copy.** Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction.

Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Amarillo Headache Clinic
Attn: Ashley Belter / HIPAA Privacy Officer
2607 Wolflin Avenue, Box 968
Amarillo, Texas 79109
806-351-2000

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

AMARILLO
HEADACHE CLINIC

2703 MOCKINGBIRD LANE
AMARILLO, TX 79109
Phone (806)351-2000
Fax (806) 351-2060

We ask that you provide us with a 24-hour notice of cancellation / rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of $45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments

Cancellations can be made by:

- **Phone – 806.351.2000 (please leave if message if not during office hours)**
- **Patient Portal (Healow) Message**
- **Email –** danaratliff@panhandleprimarycare.com

ANY QUESTIONS ABOUT CHARGES CAN BE DIRECTED TO
ashleybelter@panhandleprimarycare.com

We understand everyone's schedule is hectic and that changes can arise quickly and unexpectedly. We value your time and will do our best to accommodate your scheduling needs. We appreciate you being considerate of our time and providing advanced notice if you are unable to keep your scheduled appointment so we may accommodate other patients.

_____ _____

Signature of Patient or Legal Guardian Date

AMARILLO
HEADACHE CLINIC

PATIENT CONTRACT

We here at Amarillo Headache Clinic are making a commitment to work with you in your efforts to dial down your headache burden and improve your quality of life. To help you in this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects and your medication is not interacting with any other medication you take.
- We will help connect you with other forms of treatment to help you with your condition, such as physical therapy, chiropractic, massage, etc.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

In return, we ask that you:

- DO NOT seek out treatment for headache management, with the exception emergency/abortive treatment, that is different than the treatment plan the Amarillo Headache Clinic has prescribed. Chronic conditions such as migraines or other headache types can be difficult to manage but they can become more difficult if many providers are prescribing medications for the same condition.
- Communicate with us. We are here to be on your team and to help you. Communication is very important when treating chronic conditions.
- We want to minimize any medication interactions and maximize the benefits of treatments. Also, if we must get treatments approved through insurance, it is important to know all the treatments, dates, doses, etc.
- Let us know if you have to go to the ER/clinic after hours; If you have to do so often, your treatment regimen probably needs to be changed.
- If you choose to change your treatment regimen and go with another headache provider, please let us know and our prescribing of any medications will terminate on that date.

If you come to us after being treated by another provider for headaches, we will ask if you want to continue with Amarillo Headache Clinic or your previous provider. We do NOT believe in most cases it is a good idea for 2 providers to be treated with the same condition, especially if there is no communication (not the same EMR, etc.). In some cases, we are happy to continue to treat if you are seen by a subspecialist (example if you see someone at the Mayo Clinic once a year or if you see a provider in Houston once a year and those providers are aware you are seen in our clinic and are willing to communicate with us).

By signing this form, I agree to continued treatment at the Amarillo Headache Clinic and agree to notify them if that should change. I understand that by going to other clinics for headache treatment, I will no longer be seen at Amarillo Headache Clinic. I understand this is so that the best treatment may be provided to me.

_____ _____

Patient signature Date