Alamo Heights
PRIMARY CARE PHYSICIANS

250 E. Basse Rd., Suite 208
San Antonio, TX 78209
210-226-2424 (O) 210-226-6567 (F)
AlamoHeightsPrimaryCarePhysicians.com

Thank you for choosing Alamo Heights Primary Care Physicians.

To help expedite your check-in, please complete our New Patient Packet before your appointment.

Please bring to your appointment:

- **New Patient Packet completed**
- **New Patient Questionnaire completed**
- **Insurance Cards (primary and secondary)**
- **All medication bottles**

Dr. Jay M. Hoelscher and his team would like to ensure your experience is a pleasant one. We offer something different from other practices. As a smaller individual practice that is not owned by a large corporation or hospital system, we offer the advantage of more personalized care while still offering all the benefits including an electronic record system and secure online access to your health records & test results. We also offer TELEMEDICINE for those insurances that participate, so you can save on travel and wait times. TELEMEDICINE is great for working individuals, students, homebound patients and travelers.

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MEDICAL RELEASE AUTHORIZATION

_____

Name of Patient (Please Print) Date of Birth

_____

Street Address City, State, Zip Phone

_____

Social Security #

I hereby authorize (Please Print Doctors name and information)
_____
_____
_____

To release to:
Jay M. Hoelscher M.D
250 E. Basse Rd Suite 208
210-226-2424 O, 210-226-6567 F

I consent to release all the medical information regarding my treatment or hospitalization from my:

- General hospitalization or outpatient care
- Drug and alcohol treatment care
- Emergency room visit
- Psychiatric care
- Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

***requires special consent**

I am requesting the following information from my records (check all that apply):

- Complete Health Record(s)
- Abstract of record (includes: History & Physical, Operative Report, Laboratory Report, Radiology Reports, Consultations, Discharge summaries, and other significant findings
- Labs
- X-rays

I permit this confidential information to be released for the following purpose:

- Continuing medical treatment

The date, extent or condition upon which this authorization expires is 90 days not to exceed 24 months (except for research purposes, state **"NONE"** for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations I hereby authorize the release of all necessary medical records to Alamo Heights Primary Care Physicians. Please forward as soon as possible

_____ _____

Signature of patient or patient's representative Date

Printed name of patient's representative_____
Relationship to patient_____

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Patient Consent

I hereby give my consent for the office of Jay M. Hoelscher and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

_____ **(Patient initials)** Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials)** I understand that as part of my healthcare, Alamo Heights Primary Care Physicians. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment
* A means of communication among the many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

_____ **(Patient initials)** Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

• Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

• If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

• Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

If I do not sign this consent, or later revoke it, the office of Jay M. Hoelscher and affiliated providers may decline to provide treatment to me.

Patient Signature: _____

Patient/Patient Representative Signature: _____Date:_____

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Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below: (Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.)

Name:_____ Relationship:_____

Contact Number:_____

Name:_____ Relationship:_____

Contact Number:_____

_____No one to disclose my information out to (check)

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information**.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below). *The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

E-mail: _____

Cell: _____

Patient Name: _____

Patient/Patient Representative Signature: _____Date:_____

Revocation

I hereby revoke my request for future communications via email and/or text.

_____*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*

_____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

NOTE: This revocation only applies to communications from this Practice only.

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Financial Responsibility

By completing this form, you agree that you have read and understand our
Office policy and **Missed Appointment Policy's**.

Alamo Heights Primary Care Physicians submit claims as a curtesy for you.

- You are responsible for providing all needed verbal/written information prior to your scheduled office visit to help assist the insurance claim process. This information is used to verify your health insurance status and authorized provider assigned to you.
- Should your insurance coverage be denied and/or Dr. HOELSCHER not be your authorized provider, please be aware that you are responsible for full payment. You will be responsible for paying for your office visit "Fee for Service" in full at the time of medical service.
- You will be responsible for following up with your insurance carrier for reimbursement if applicable.
- If you claim gets denied for any reason including "not medically necessary" we will only appeal the claim one time. Then it is your responsibility to pay our office and seek reimbursement through the insurance you have chosen

- You understand and agree to pay a $45.00 fee for every missed appointment if that appointment is not cancelled with at least 24 hours' notice to the practice.

Please fill out the information below. Your signature will indicate that you have read, understood, and agree with the Office policy and missed appointment policy as stated in our Patient Health Contract. If you would like a copy of the office policy please request the copy before you leave from your appointment.

_____ _____
Signature of Patient Date

It is our policy to collect debit/credit card information to have on file in the event of a missed appointment without proper advance notice. Your information will be kept private and will only be used if you incur a Missed Appointment Fee.

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
Cardholder Name: _____
Credit Card Number:_____
Expiration Date:_____/_____/_____
Zipcode:_____

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Alamo Heights PRIMARY CARE PHYSICIANS

OFFICE POLICIES

To properly serve you, we have developed our policies below to promote an organized treatment experience. Please review this very important information below and again, thank you for being our patient.

Your first visit with Dr. Hoelscher is to establish care as a new patient. At this appointment we review your medical history and medications, begin the process of gathering previous medical records, address acute concerns, and provide medication refills when needed. The front desk staff will also collect the necessary billing information and ask you to read and sign the new patient packet. The doctor will address specific areas of concerns with your health that you may have during your first visit as well. Dr. Hoelscher then has the knowledge to order the appropriate labs and can make a plan of care. AFTER the initial visit to establish care, an "Annual Physical" can be scheduled. When possible, labs will be ordered BEFORE the annual visit so the results can be discussed IN PERSON to allow the opportunity to ask questions and have direct interaction with the doctor. Dr. Hoelscher feels the face-to-face discussion of results is the best way to care for you because it provides the best communication. Please understand the services provided during the first visit to establish care are unique. They are NOT intended to be your "annual visit" and cannot be billed as such.

(PLEASE INITIAL BESIDE EACH SECTION INDICATING YOUR UNDERSTANDING AND ACCEPTABLE OF OUR POLICIES.)

_____ In order to better serve you, we ask that you arrive 15 minutes before your scheduled time. If you are late for your appointment, the physician will not be able to address all medical issues during your visit and may even request that you reschedule for another time. We make every effort to see patients in a timely fashion and your prompt arrival and avoidance of missed appointments helps us schedule appropriately to accomplish this.

_____Please provide us with all necessary insurance information and bring the card and a valid form of picture identification with you to each and every visit. Inform us of any changes in your health insurance status or demographic and contact information within 7 days of your visit, as we need time to verify your coverage. Late notification of this may result in a rescheduled appointment.

_____If we DO participate with your insurance plan**, your co-payment as well as any insurance deductible amount that is your responsibility will be collected before being seen by the physician**. This will include any past due payments. There may be additional charges over and above your co-payment due at the time of your appointment depending on your specific insurance benefits package.

_____ If we DO NOT participate in your insurance plan or you have no insurance, full payment of all charges is expected at the time of your appointment prior to seeing the physician.

_____Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

_____ If you need specialized equipment through a DME company, you will be required to call your insurance to see what company they use so we can submit the request.

_____ Referrals can take up to 14 business days to complete.

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_____ Alamo Heights Primary Care Physicians has a no tolerance policy for verbal abuse from patients or family members/caretakers of patients. We understand the medical field can be very difficult but proper communication is needed for care. If there are any issues please contact the manager through the private patient portal.

_____ We accept Mastercard, Visa, Discover, a local personal check with ID, and cash. A service fee of $35 will be assessed for all returned checks to cover bank charges.

_____ Please bring to your appointment all the actual bottles or boxes of medications, vitamins, or supplements (prescription or over-the-counter) that you take regularly or an updated written list of your active medications and dosages you are actually taking. If you are a diabetic patient, please bring a log of your glucose readings to each visit.

_____Prescriptions are a high priority for us. **The fastest way to get your refill is by calling your pharmacist** and giving them your prescription number located on the label on the bottle, or by utilizing the automated refill system many pharmacies have in place. When no further refills are available, continued refill authorization **will require an office visit** for the chronic condition within the past 6 months. (acute visits do not comply for this refill)

_____Narcotic, anti-anxiety medication, and any other controlled substance refills will require you to be seen each time for a written prescription in order to comply with the standard of care for medical documentation as to the reason for the ongoing need for treatment, We will refer to a specialist if this is needed for long term treatment. A Urine toxicology screening will be required. Please note **ALAMO HEIGHTS PRIMARY CARE PHYSICIANS WILL NOT PRESCRIBE CONTROLLED MEDICATIONS ON YOUR FIRST VISIT**. Finally, please allow for at least 3 business days for us to process your refill authorization to ensure there is no interruption in your care.

_____ If your prescription requires a prior authorization, please allow 72 hours for this to be complete. We are at the mercy of your insurance to respond to our request. If the authorization was denied it will be your responsibility to call your insurance to see what is on your formulary and what medication is in your budget.

_____We will give you a courtesy call 2 business days prior to your appointment as a reminder. Missed patient appointments create problems in scheduling that affect not only you but also the rest of the patients in the practice. We realize there may be unforeseen circumstances that lead to a need to reschedule an appointment. In such cases we request to be notified of your cancellation 24 hours prior to your appointment time. If insufficient or no notice is given, a cancellation fee in the amount of $45 will be for your appointment. If you have 4 missed appointments without notification (“no shows”) in a 2-year period, we will unfortunately need to end the physician-patient relationship and you will be terminated from the practice.

_____Paperwork including letters, insurance forms, FMLA papers, and other forms needing to be completed by Dr. Hoelscher take significant time. Depending on how many pages need to be completed the cost will ranges from $60-150.00 per form. Please allow for 7 business days for these to be done. An additional $50 fee will be assessed for forms presented in less than the required time allotment. Payment will be due at the time the forms are presented for completion.

_____Dr. Hoelscher will schedule a follow-up appointment with you to discuss in person the results of labs and Xrays he has ordered. He feels this is the absolute best way to be able to answer your questions regarding the results and formulate a plan of care. Once he has had the opportunity to consult with you about the results, they will be posted on your private patient portal for you to reference as you desire. We encourage each patient to sign up for access to this portal through our website at www.AlamoHeightsPrimaryCarePhysicians.com.

If you have any questions regarding your appointment, please feel free to contact our office at (210) 226-2424.
Our dedicated staff will be happy to assist you.

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NOTICE OF PRIVACY PRACTICES

Alamo Heights Primary Care Physicians
250 E. Basse Rd. Suite 208
San Antonio, TX 78209

Effective Date: September 23, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, on a computer, and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care

professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Officer.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. Copyright 2013 American Medical Association. All rights reserved

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional

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judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

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B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

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6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.
If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
Jorge Lozano, Regional Manage, Office for Civil Rights U.S. Department of Health and Human Services 1301 Young Street, Suite 1169, Dallas, TX 75202 Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697]
OCRMail@hhs.gov
The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.
You will not be penalized in any way for filing a complaint.

Privacy Officer:
Renee Hoelscher
Address: 250 E. Basse Rd. Suite 208 San Antonio TX 78209
Phone: 210-226-2424 Fax: 210-226-6567

Alamo Heights
PRIMARY CARE PHYSICIANS

INSURANCE COVERAGE WAIVER/ CASH PAY

I understand that my eligibility for coverage by _____ (name of insurance company) **cannot be confirmed** at this time. I wish to receive medical services from Jay M. Hoelscher, M.D. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided

*Signature of Patient/Legal Guardian*_____*Date*_____

250 E. Basse Suite 208 San Antonio, TX 78209
210-226-2424

Alamo Heights Primary Care Physicians

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Alamo heights Primary Care Physicians at 210-226-2424.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Witness Signature	Date