Centric Physicians
Patient Focused, Physician Centered
Outcome Driven

LAURA GIVENS M.D., CMD, FACHE
CHIEF EXECUTIVE OFFICER

NEW PATIENT WELCOME LETTER

Centric Physicians would like to take this opportunity to welcome you to our practice and to thank you for choosing us and allowing us to participate in your care. We look forward to providing you with personalized, comprehensive healthcare focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our medical and behavioral health providers work closely in a "team approach" to support your well-being.

In an effort to meet the busy lifestyles of our patients, our clinic hours are 8:30 am to 4:00 pm Monday through Friday.

Our mission is to provide outstanding quality health care to our patients. In an effort to keep the costs of health care affordable, we have developed office policies and procedures regarding patient care and payment.

Our patients can expect from us:

- A high level of professional skill and ability
- Dedication to your health care needs
- A safe environment to discuss your concerns
- Fees that are appropriate for the services provided

In return, we expect from our patients:

- Cooperation in making and keeping appointments
- Showing up to your appointments on time
- Bring your Photo ID, Insurance Card, and payment for fees to every visit

We want to promote effective and open communication with our patients. If you have a concern, please discuss it directly with your provider or feel free to call (210) 640- 9772 to speak to management staff.

We encourage you to visit our website at www.CentricPhysicians.com and get to know our providers and the different services we offer.

Thank you again for partnering with us to provide for your health care needs.

Sincerely,

Laura Givens
Chief Executive Officer

Boerne Clinic
17 Old San Antonio Road, Suite 202
Boerne, TX 78006
(830) 214-7714

Stone Oak Clinic
540 Oak Centre Drive, Suite 260
San Antonio, TX 78258
(210) 640-9772

Privacy/HIPAA Policies & Procedures
Notice of Privacy Practices

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

This Company is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact us at 830-267-4575.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our practice, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

* ensure it is accurate
* better understand who may access your health information
* make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. We may also disclose health information about you to people outside the Company who may be involved in your medical care after you leave our care. This may include family members, or visiting nurses to provide care in your home.

For Payment. We may use and disclose health information about you so that the treatment and services you receive may be billed to you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and for developing and evaluating clinical protocols. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.

OTHER ALLOWABLE USES OR DISCLOSURES

We may also use or disclose your information for certain other purposes allowed by 45 CFR Part 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the heath or safety of others
- As required by state or federal la such as reporting abuse, neglect or certain other events
- As allowed by Worker's compensation laws for use in worker's compensation proceedings
- For certain public health activities such as reporting certain diseases
- For certain public health oversight activities such as audits, investigations, or licensure actions
- In response to a court order, warrant or subpoena in judicial or administrative proceedings
- For certain specialized government functions such as the military or correctional institutions
- For research purposes if certain conditions are satisfied
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties

Uses and Disclosures With Your Written Authorization:

Other than the uses and disclosures described above, we will not use or disclose medical information about you without an “authorization” that is signed by you o, if you are unable to sign the authorization, by your personal representative. For example, we may wish to use or disclose your health information for reasons other than those that are described above, and before we can use or disclose your health information, we must obtain your permission to do so. In those instances, you may contact us to ask us to disclose your health information. Before we can disclose your health information we will ask you to sign an authorization form that gives us permission to do so.

If you sign a written authorization allowing us to disclose health information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). You may revoke your authorization by submitting a written notice to the Privacy Officer identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

Your Health information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g. if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g. if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.
- You may receive notification of a breach of your unsecured PHI.
- You may revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action ha already been taken based on a prior authorization).

Changes To This Notice:

We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our resection area and on our website. You may obtain a copy of the operative Notice from our receptionist or the Privacy Officer.

Complaints:

If you believe Centric Physicians misused or disclosed your health information improperly, you may file a complaint with Centric Physicians by contacting our Privacy Officer as listed below. Alternatively, you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.
We cannot, and will not, require you to waive the right to file a complaint as a condition of receiving treatment from the Practice. We cannot, and will not, retaliate against you for filing a complaint.

Privacy Officer
Centric Physicians Group
113 Pleasant Valley Drive, Suite #210
Boerne, TX 78006

or

Office of Civil Rights OCRComplaint@hhs.gov

PLEASE COMPLETE THIS SECTION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Practice Name: CENTRIC PHYSICIANS GROUP

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____ ____/____/____

Print Name Date of Birth

_____ ____/____/____

Patient (or Patient Representative*) Signature Today's Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

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Medical Records Release

PLEASE COMPLETE THIS FORM IF: ❑ We do not have records from your previous provider(s)
❑ You wish to have Centric Physicians release your records to someone else

Authorization for Release of Personal Health Information (PHI)

Must Be Completed For All Authorizations:

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affect treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____ SSN: _____

Person/organization providing the information:	**Person/organization receiving the information:**
_____	_____
_____	_____
_____	_____
_____	_____

The purpose for this authorized release of information is:_____
_____

❑ At the request of the individual

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked they cannot be released.

❑ Drug Abuse ❑ Substance Abuse ❑ Psychological or Psychiatric conditions ❑ AIDS/HIV

Please release the following records:
❑ All records generated in your office
❑ Other: _____
(Specific dates of treatment or specific description or information requested)

Are you leaving our practice? ❑ Yes ❑ No
If yes, please explain: _____

Must be Completed For All Authorizations:

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations, and that the information may be re-disclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

_____ _____ _____
Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**

Revocation of Authorization:

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby revoke this authorization, effective____/____/____

_____ _____ _____
Patient Signature (Representative) **Date** **Printed Name of Patient (Representative)**

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Patient's Authorized Contacts

Patient's Name (please print) _____ Today's Date _____

Patient's Birthdate _____

Who Can Centric Physicians Contact Regarding Your Care and Billing?

Contact persons with whom we may discuss your care, give test results and account and billing information:

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name _____Relationship _____ Phone #_____

Name _____Relationship _____ Phone #_____

May we leave confidential information on voicemail or answering machines listed below?

Home Phone_____ ❑ Yes ❑ No

Work Phone _____ ❑ Yes ❑ No

Cell Phone _____ ❑ Yes ❑ No

Patient Signature: _____ Date:_____

Patient Registration Form

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Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		Family Physician or Pediatrician:
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ Hispanic ☐ Other ☐ American Indian or Alaska Native ☐ Black or African American ☐ Decline ☐ Asian ☐ Native Hawaiian or Pacific Islander	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have read and agree to Centric Physician Group's (CPG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to CPG all money to which I am entitled for medical expenses related to the services performed from time to time by CPG, but not to exceed my indebtedness to CPG. I authorize CPG to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to CPG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Centric Physician Group's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____

PATIENT MEDICAL HISTORY

NAME:_____ **DOB**:_____/_____/_____ **DATE**:_____/_____/_____

Reason you are being seen today?

_____

_____

PERSONAL MEDICAL HISTORY: (Please circle/ fill in all that apply)

- ☐ ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia (irregular heart beat)
- ☐ Arthritis
- ☐ Bipolar
- ☐ Bladder problems
- ☐ Bleeding problems
- ☐ Cancer: _____
- ☐ Carpal Tunnel
- ☐ Headaches
- ☐ Crohn's disease
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: 1 or 2
- ☐ DVT
- ☐ Gallstones
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Lupus
- ☐ Liver disease
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peripheral vascular disease
- ☐ Peptic ulcer
- ☐ Psoriasis
- ☐ Pulmonary embolism
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disorder

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate date when they were performed.

_____

_____

SOCIAL HISTORY:

Recreational Drug Use: ☐ Current ☐ Past ☐ Never

Smoking: ☐ Current ☐ Past ☐ Never Packs/ day:_____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/ day:_____

FAMILY MEDICAL HISTORY: Does your family have any chronic medical conditions?

Father:_____

Mother:_____

Covid Vaccine	☐ Yes, I've taken it ☐ No, but I plan on it ☐ I have refused it	Date Received: see side column
*****Flu Vaccine**	☐ Yes, I've taken it ☐ No, but I plan on it ☐ I have refused it	
Pneumococcal Vaccine	☐ Yes ☐ No Date:	
Eye Exam	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐
Dxa (Bone Density)	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐
Prostate Exam	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐
Colonoscopy	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐
Mammogram	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐
Well Woman Exam	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐
Last Menstrual Period	☐ Yes ☐ No Date:	Normal ☐ Abnormal ☐

Covid Vaccine:
Moderna -
1st injection date: _____
2nd injection date: _____
Pfizer -
1st injection date: _____
2nd injection date: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Please include specific doses and when they are taken. If you don't know, please call your pharmacist to confirm.

Medications

OTC and Vitamins

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES:

_____

Other Allergies:

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____
_____

MA Review of Systems:

_____
_____

Patient signature:_____ Date: _____

What is the difference between an Annual Physical and an Office Visit?

An Annual Physical, Preventive, Or Wellness Visit

Is a visit focused on preventive care and immunizations.

Physical Exams may include:
- Pediatric – Development & Growth
- Female – Pap smears & Breast Exams
- Male – Prostate & Testicular Screenings
- Skin check

Healthy Lifestyles discussion
Immunizations
Lab testing as appropriate
Coordination of care/referrals for additional screenings:
- Mammograms
- Colonoscopies
- Eye Exams
- Other

Wellness visits are usually copay exempt.
If new or chronic conditions are addressed an office visit will also be performed and billed.

An Office Visit, Sick Visit Or Medication Check

Is an appointment where we discuss and evaluate new or existing medical conditions.

Office visit/Follow up appointment

- Evaluate & treat symptoms and concerns
- Address chronic problems
- Adjust medications & process refills
- Laboratory testing if necessary
- Process referrals if necessary

Copays, Deductibles and Co-Insurance may apply.

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FAQ FOR ALL NEW AND ANNUAL VISIT PATIENTS

Date:_____/_____/_____

Patient Name: _____

DOB:_____/_____/_____

Please complete this Functional Activities Questionnaire utilizing the following scoring system:

- Dependent = **3**
- Require assistance = **2**
- Have difficulty but do by myself = **1**
- Normal = **0**
- Never did the activity, but could do now = **0**
- Never did activity and would have difficulty now = **1**

Activity	Score
Writing checks, paying bills, balancing checkbook	
Assembling tax records, business affairs, or papers	
Shopping alone for clothes, household necessities, or groceries	
Playing a game of skill, working on a hobby	
Heating water, making a cup of coffee, turning off stove after use	
Preparing a balanced meal	
Keeping track of current events	
Paying attention to, understanding, discussing TV, book, magazine	
Remembering appointments, family occasions, holidays, medications	
Traveling out of neighborhood, driving, arranging to take buses	
TOTAL SCORE:	

Patient signature:_____ Date:_____/_____/_____

LAURA GIVENS M.D., CMD, FACHE
CHIEF EXECUTIVE OFFICER

Late Policy

New patients are required to arrive 30 minutes prior to their appointment time in order to complete paperwork. If any patient is not present and ready to be seen 15 minutes after their scheduled appointment, they will be required to reschedule their appointment. Patients are given designated time slots which we must abide by out of courtesy to the other patients.

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Centric Physicians reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which are not canceled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Two "no shows" in any 12-month period could result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

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17 Old San Antonio Road, Suite 202
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