Jordan Mitchell M.D.

OBSTETRICS/GYNECOLOGY

Our goal at Jordan L Mitchell MD is to put the patient first by providing outstanding service to each and every patient, each and every visit. In keeping with our policy to educate in the areas of medicine and insurance, we would like to let you know that if you are here for an annual well woman exam we will only discuss details or perform services applicable to a well woman exam. If there are medical issues that you would like to discuss with Dr. Mitchell that fall outside of a well woman exam, you will be rescheduled for a problem visit at another date/time. Of course if your problem is emergent, we will address the problem today but will be required to reschedule the annual well woman exam.

If for any reason a problem visit is handled on the same day as an annual visit, the insurance will be billed for each service separately. Depending on your personal insurance benefits, you may be responsible for any out of pocket costs associated with the additional services billed to insurance.

If you have any questions or concerns regarding this policy please ask our staff.

Thank you,

Jordan Mitchell MD & Staff

Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

APPOINTMENT POLICY

We value our patients and the time we spend with each of you and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office at least 24 hours in advance to cancel or reschedule. Appointments cancelled without a 24 hour advance notice will be charged $25.

Thank you

_____

Patient name *(printed)* Signature of Patient or Guardian

_____

Printed name of Guardian Guardian's Relationship to Patient

_____

Date

Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

Authorization for Use and Disclosure of Protected Health Information

I_____, hereby authorize, Dr. Jordan Mitchell to use and/or disclose the following **protected health information (PHI)** to:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

May we leave a voicemail regarding medical information?

□ YES □ NO

□ Cell phone □ Home phone □ Work phone

This PHI is being used or disclosed for the following purposes:

Provide appointment reminders
Describe or recommending treatment alternatives
Providing information about health-related benefits and services that may be of interest to the individual.
Soliciting funds to benefit the covered entity

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the 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 privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization.

The use or disclosure requested in this authorization will result in direct and indirect compensation to **Jordan Mitchell, M.D.** from a third party.

This authorization will remain in effect until further notice from patient or legal guardian of the patient.

_____ _____

Signature of the patient or representative/Guardian Date

_____

Print Name of Patient or Representative/Guardian

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We believe in providing professional care for your most intimate health needs. In an effort to maintain this high quality of care, we would like to share this information with you in regarding your medical insurance.

Your medical insurance is a tremendous benefit that your employer provides for you or you purchase privately for yourself. Many times, understanding your benefits is confusing! We will do our best to assist you in this area, but keep in mind that because we are a third party, we have limited access to information regarding your medical benefits. We feel it is important that you understand how your insurance works. Remember that your employer or you have chosen this plan and benefits, not your physician. We are not involved with your insurance company in any way. Many plans have specific restrictions that you need to be aware of and you should consult your insurance handbook for these details.

Regardless of what we might calculate as your medical plan benefit in dollars, we must stress the fact that **you are responsible for the TOTAL cost of your medical treatment.** We will file the claim and do our best to process and coordinate payment from your insurance company.

Please keep in mind that **your insurance company will never guarantee your benefits** or tell us exactly what they are paid directly to us. That is why we can only estimate your portion. We ask that you pay your estimated portion and deductibles at the time of service. If you are unable to pay this estimated portion today we will be more than happy to reschedule your appointment at a later date.

Thank you for your understanding and cooperation.

_____ _____

Signature of the patient or representative/Guardian Date

_____

Print the name of the patient or representative/Guardian

Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

Jordan Mitchell M.D.

4461 Coit Rd Ste 211 Frisco, TX 75035
Phone: 214-297-0008 Fax: 214-297-0001

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date: _____

Previous Name: _____ Social Security # _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Dr. Jordan Mitchell

Address: 4461 Coit Road Ste. 211

City: Frisco State: TX Zip: 75035

This request and authorization applies to :

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All Healthcare information

☐ Other : _____

This authorization includes the release of information about the following, if it included in the medical record, AIDS, HIV related information or testing, psychiatric disorders, drug treatment, and/or alcohol treatment. The specific dates of such records to be disclosed include :_____ I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined in HIPAA to ensure accuracy. I understand that I have a right to limit the type of information release and to revoke this authorization by submitting a notice, in writing to you. Unless revoked, this authorization will expire on the following date: _____. If I chose to limit the information released, I understand that you may inform the requestor that portions of the record have been withheld. You are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

I understand that information will be provided within 15 days from receipt of request and a fee for preparing and furnishing this information may be charged to me according to the rulings set forth by the Texas State Board Of Medical Examiners.

_____

Patient Name {Printed} Signature of Patient or Guardian

_____

Printed Name of Guardian Guardian's Relationship to Patient

Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

NOTICE OF PRIVACY PRACTICES FOR JORDAN L MITCHELL, M.D.

THIS NOTICE DESCRIVES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLODED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The portability of health insurance and accountability of the 1996 Act ("HIPPA") is a federal requiring all medical records and other information of identifiable health individually used or disclosed by us in any manner, whether electronically, on paper or by mouth, are confidential correctly. This law, the patient, significant offers new rights to understand and control how their health information is used, "HIPPA" provides sanctions covered entitles that misuse of personal health information.

As required by ("HIPPA") have prepared this explanation of how we are obliged to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your health care provider records of only for each of the following purposes: treatment, payment and health care operations.

Treatment means to facilitate, coordinate, or administration of health care and related associated one or more health care providers. An example of this would include a physical examination.

Payment means activities such as obtaining the reimbursement of services, confirming the coverage, billing and collection and utilization review activities. An example of this would be to send a bill for your visit to your insurance for payment company.

Health care operations include the business aspects of our practice, such as execution quality assessment and improvement activities, functions and analysis of cost management, audit and service to the client. An example would be an internal quality assessment review.

We can also create and distribute, identified health information by removing all references to identifiable individual information.

We can contact you to provide appointment notices or information on alternative treatment or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your permission in writing. You many revoke such authorization in writing and we are required to honor and abide by that written request, unless we have already taken actions rely on authorization.

Have the following rights with respect to your protected information of health that you can exercise to submit a request in writing to the privacy officer.

The right to the restrictions of application for certain uses and disclosures of protected health, including information related to disclosures to members of the family, other relatives, close personal friends, or any other person identified by you. We are, however, it is not necessary to accept a restriction request. If we agree a restriction, must fulfill us her unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health from us by alternative means or at alternative locations information. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a copy of the role of this notice from us upon request.

We are required by law to maintain privacy of your protected health information and that provide you to this notice of our legal and practical requirements of privacy with respect to protected health information.This notice is effective as of April 14 th 2003 and they are required to abide by the terms of the note of practices of privacy currently in force.We reserve the right to change the terms of note out of privacy practices and to make the new Notice effective for all provisions protect the health information that should be maintained. We will publish and you may request a written copy of a revised notice of privacy practices of this Office.

You use if you feel that its protection of privacy has been violated. You have the right to submit written complaint with our office or the Department of health & Human Services, Office of civil rights violations of the provisions of this notice or the policies and procedures to our Office. We will not retaliate against you for filling a complaint.

For more information about HIPPA or file a complaint:

The Unidos.Departamento States of health & Human Services Office of civil rights

200 Avenue, southwest of independence

Washington, DC 20201

(202) 619-0257

Toll free: 1-877-696-6775

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are obliged to abide by such restrictions.

_____ _____
Signature of the patient or representative/Guardian date

_____
Print the name of the patient or representative/Guardian

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REGISTRATION FORM

(Please print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑Mr. ❑Ms.	❑Miss ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is it her legal name? ❑Yes ❑No	If not so, what is your legal name?	(Former name):	Date of birth: / /	Age:	Sex: ❑M ❑F	
Street address:		Social security no.:	Home phone #: Cell phone #:			
P.O. box:	City:	State:	Zip code:			
Occupation:	Employer:	Employer's phone no.: ( )				
Chose clinic because / Referred to clinic by (Please check one box):		❑Dr.	❑Insurance plan	❑hospital		
❑Family	❑Friend	❑Close to home/Work	❑Other	Other relatives seen here:		
Pharmacy:		Pharmacy phone number:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person in charge of Bill:	Date of birth: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑Yes ❑No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑Yes ❑No					
Name of primary insurance	Address:				
Name of the primary insured:	Primary insured S.S. no.:	Date of birth: / /	Policy no.:	Group no.:	Copayment: $
Patient's relationship to primary insured:	❑Self	❑Spouse	❑Child	❑Other	
Name of secondary insurance (if applicable):	Primary insured name:	Policy no.:	Group no.:		
Patient's relationship to primary insured:	❑Self	❑Spouse	❑Child	❑Other	

IN CASE OF EMERGENCY

Name of local friend or relative (Not living at the same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jordan L Mitchell MD or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PARENTAL CONSENT FOR TREATMENT OF A MINOR

I,_____, give Dr. Jordan Mitchell permission to provide treatment to the minor listed below including, but not limited to, vaginal examination pap smear, and venipuncture.

Minor Patient's name:_____

Date of Birth:_____

Legal Parent/Guardian Name Printed:_____

Legal Parent/Guardian Signature:_____ Date:_____