Arbor Mental Health & Family Medical Center
6326 Sovereign Dr, Suite 601, San Antonio, TX 78229
(726) 208-7900   FAX (726) 208-2200

WELCOME! The providers and staff at **Arbor Mental Health & Family Medical Center (AMHFMC)** would like to take this opportunity to welcome you and thank you for choosing **AMHFMC** as your health care provider. We understand that you have a choice in selecting your primary care provider.

Our providers and staff of licensed vocational nurses, medical technologists and medical assistants are well qualified, knowledgeable and dedicated to delivering the best possible care to you. Our administrative staff members provide a valuable service by facilitating the processing of most paperwork related to the medical care that you receive.

Our office is located in the northwest portion of San Antonio. Our services include obtaining blood specimens for laboratory analysis, electrocardiograms (ECGs) to determine cardiac (heart) functioning and other specialized testing services. We have all the equipment necessary for completing comprehensive physical exams and for performing minor procedures.

We are utilizing a paperless electronic medical record (EMR): eClinicalWorks. **AMHFMC** uses a Patient Portal to facilitate patient-to-clinic communication. This system allows better communication with labs, pharmacies, consulting provider, hospitals, and patients.

Our goal is to be available to you to meet your medical needs. Our business hours are 8:00 a.m. to 5:00 p.m. on Monday's & Friday's and 8:00 a.m. to 9:00 p.m. Tuesday through Thursday's. If your condition is **"life threatening"** such as severe chest pain, traumatic injury, unconsciousness or uncontrollable bleeding, call 911 or go to the nearest emergency facility. Notify our office of your emergency treatment as soon as possible.

We **do not** admit patients to any local hospitals. All local hospitals have admitting provider available for inpatient care and management of our patients.

To better serve you during your initial visit to our office, please remember to bring **your insurance card, driver's license or ID, containers of all medications you are taking and all the enclosed paperwork, signed and completed.** Additionally, you should arrive approximately 30 minutes prior to your scheduled appointment time in case completion of additional forms is required. For **every subsequent visit** please again bring your insurance card and medication containers or a list of your medications and dosages that you are taking.

We look forward to working with you to provide medical care during periods of illness and to support and promote your continued good health. Please feel free to ask questions or bring any concerns you may have to the attention of our staff. We strive to provide efficient, accessible, quality medical care within a caring environment to you and your family. We are looking forward to meeting and welcoming you into our family of patients.

Sincerely,

The Providers and Staff at AMHFMC

Arbor Mental Health & Family Medical Center

ADULT HEALTH QUESTIONNAIRE

In order to provide the best medical care possible, your provider must know not only what your present symptoms are but also what diseases you have and what problems you may be at risk for developing. For this reason you are requested to carefully fill out this screening health questionnaire. This along with the history and examination your doctor obtains when you visit him will provide a complete medical evaluation of your current and potential medical problems.
This **MUST** be completed prior to your first office visit.

DATE:______________________________

NAME:____**AGE:**_________**SEX:**________**RACE:**____________

In a few words please state why you are coming to see the doctor: ____

MEDICAL PROBLEMS: **CONDITION** **YEAR OF ONSET** **STATUS**

INJURIES: Please list serious injuries and broken bones with approximate dates.

OPERATIONS: Please list the operations you have had. Do not omit minor operations such as tonsils, vasectomy, D&C, etc.

Date	Operation	Hospital	Surgeon

HOSPITALIZATIONS: Please list your hospitalizations other than those described above.

Date	Illness	Hospital	Physician

ALLERGIES:

Medication	Type of Reaction	Date of Reaction

MEDICATIONS: Please list in detail all the medications you take. Do not forget birth control, sleeping pills, vitamins, etc

Medication mgs when taken	**Medication** mgs when taken

Have you ever taken blood pressure pills? Yes ☐ No ☐

MARITAL STATUS: Married ☐ Single ☐ Widow/Widower ☐ Divorced ☐ Living with significant other ☐

Name of spouse or significant other:______________________________

EDUCATION: (highest level attained and where) ______________________________

HABITS: Please indicate your average consumption (per day/week/month) of the following and how long you have used them.

Whisky______________________ Coffee______________________

Beer______________________ Tea______________________

Wine______________________ Cigarettes______________________

Marijuana______________________ Pipes & Cigars______________________

EMPLOYMENT:

What type of work do you do? ______________________________

What type of work does your spouse do? ______________________________

IMMUNIZATIONS: Please indicate the last date or year you received each of the following immunizations:

Tetanus______________ Influenza (flu) ______________ Pneumonia vaccine______________

Hepatitis B______________Measles/Mumps/Rubella (MMR) ______________

Other Vaccines______________ TB Skin Test______________Positive ☐ Negative ☐

FAMILY MEDICAL HISTORY: **Medical Problems or Cause of Death** **Age(s) if Alive** **Age(s) at Death**

Spouse ______________________________

Mother ______________________________

Father ______________________________

Brothers ______________________________

Sisters______________________________

Children ______________________________

Maternal Grandmother ______________________________

Maternal Grandfather ______________________________

Paternal Grandmother ______________________________

Paternal Grandfather ______________________________

Check if any *blood relatives* has or has had any of the following and enter relationship. Please include yourself.

	Yes	No	Relative
Alcoholism	☐	☐	
Arthritis	☐	☐	
Bleeding Disorder	☐	☐	
Cancer	☐	☐	
Dementia	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure			
Kidney Disease/Stone	☐	☐	
Migraine Headaches	☐	☐	
Depression	☐	☐	
Osteoporosis	☐	☐	
Stroke	☐	☐	
Tuberculosis (TB)	☐	☐	

Other ____

____

INFECTIONS: Please give the approximate age when you had each of the following:

Tuberculosis ____________ Rheumatic Fever ____________ Hepatitis ____________

Other ____

HEALTH MAINTENANCE: When did you last have any of the following and give any details that you know?

[✔] place check if never done

- ☐ Blood Transfusion ____
- ☐ Chest X-ray ____
- ☐ Cholesterol ____
- ☐ Bone Density ____
- ☐ Electrocardiogram (ECG) ____
- ☐ Heart Stress Test ____
- ☐ Mammogram ____
- ☐ PSA ____
- ☐ Sigmoid or Colonoscopy ____
- ☐ Upper GI series ____

WOMEN:

Date of last pelvic exam: ____________ Date of last PAP smear: ____________

Date of last menstrual period: ____________ Do you use birth control pills? ☐ Yes ☐ No

Menstrual period: Age at onset ____________ Days between periods? ____________ Duration of flow? ____________

Number of pregnancies? ________ Number of live births? ________ Number of miscarriages / abortions? ________

Weight of largest baby? ________

During pregnancy did you have any of the following?

	Yes	No
Diabetes	☐	☐
High blood pressure	☐	☐
Protein in urine	☐	☐
Seizures	☐	☐
Swelling of ankles	☐	☐

Other Complications ____

PLEASE ATTACH ANY OTHER SIGNIFICANT ADDITIONAL INFORMATION

AMHFMC REVIEW OF SYSTEMS FORM

PATIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH	DATE

IN THE LAST 3-6 MONTHS HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO.

GENERAL	Yes	No
Fatigue		
Fever		
Intolerance to heat or cold		
Night sweats		
Trouble sleeping		
Unexpected weight gain		
Unexpected weight loss		

VISION		
Blurred/double vision		
Excessive tearing		
Pain		
Redness		

EARS		
Decreased hearing		
Drainage		
Pain		
Ringing		

NOSE		
Excessive runny nose		
Excessive sneezing		
Nosebleeds		
Sinus Pain		
Stuffy or congested nose		

MOUTH		
Change in taste		
Dentures		
Lip sores		
Sore or bleeding gums		
Sore tongue		

THROAT		
Persistent hoarseness		
Sore throat		
Trouble swallowing		

NECK		
Lumps or swelling		
Pain		

LUNGS	Yes	No
Coughing excessive phlegm		
Coughing spells		
Coughing up blood		
Difficulty breathing		
Wheezing		

HEART		
Chest pain or tightness		
Cramps in legs on walking		
Fainting spells		
Irregular heartbeat		
Palpitations		
Racing of fast heartbeat		
Swollen ankles		

DIGESTIVE		
Abdominal pain		
Black or tarry stools		
Blood in stools		
Change in appetite		
Constipation		
Diarrhea		
Difficult or painful swallowing		
Heartburn or indigestion		
Milk intolerance		
Nausea		
Vomiting		
Vomiting of blood		

MALE		
Pain or swelling in scrotum		
Penile discharge		

FEMALE		
Breast pain or lumps		
Heavy bleeding		
Hot flashes		
Irregular periods		
Pain or bleeding with sex		
Unusually painful periods		
Vaginal discharge		
Vaginal itching		

URINARY	Yes	No
Blood in urine		
Burning on urination		
Incontinence or losing urine		
Frequent urination		
Frequent urination at night		
Straining to urinate		

NERVOUS SYSTEM		
Dizziness		
Headaches		
Muscle weakness/twitching		
Numbness		
Paralysis		
Seizures		
Tremors		
Trouble speaking		
Trouble walking		

BONES, JOINTS, MUSCLES		
Pain in ankles/knees/feet		
Pain in back/neck		
Pain in shoulders/arms/hands		
Pain in joints		
Pain in muscles		
Swollen joints		

SKIN		
Allergic or sensitive skin		
Change in mole or birthmark		
Easy bleeding or bruising		
Hives		
Rash		

MENTAL HEALTH		
Excessive crying or worry		
Feeling blue or depressed		
Hopeless feelings		
Insomnia		
Sexual problems		
Stress at work or home		
Thoughts of hurting self		
Work or family problems		

PLEASE NOTE ANY COMMENTS IN THE SPACE BELOW

AMHFMC PATIENT INFORMATION FORM

PATIENT NAME: ____________________ ____________________ ______________
Last Name First Name Middle

DATE OF BIRTH:________________________ OTHER ____________________

ADDRESS: ____________________ ______________ __________ __________
CITY STATE ZIP CODE

HOME PHONE #:____________________CELL PHONE #: ____________________

EMAIL ADDRESS:____________________REFERRED BY: ____________________

EMPLOYER:____________________WORK PHONE #: ____________________

SPOUSE'S NAME:____________________WORK PHONE #: ____________________

EMERGENCY CONTACT INFORMATION OTHER THAN SPOUSE:

CONTACT NAME:____________________RELATIONSHIP:______________

ADDRESS:____

HOME #:______________WORK #:______________OTHER #:______________

PRIMARY INSURANCE

INSURANCE CARRIER:____________________PHONE #: ______________

MEMBER I.D. #:____________________GROUP #: ____________________

POLICY HOLDER INFORMATION IF OTHER THAN PATIENT:

NAME:______________DOB:__________EMPLOYER:______________

WORK #:______________RELATIONSHIP TO POLICY HOLDER: ______________

SECONDARY INSURANCE

INSURANCE CARRIER:____________________PHONE #: ______________

MEMBER I.D. #:____________________GROUP #: ____________________

POLICY HOLDER INFORMATION IF OTHER THAN PATIENT:

NAME:______________DOB:__________EMPLOYER:______________

WORK #:______________RELATIONSHIP TO POLICY HOLDER: ______________

I hereby assign the benefits from any insurance or third party to AMHFMC for medical services provided to me. I understand that AMHFMC has the right to decline or accept assignment of such benefits. If these benefits are not assigned to AMHFMC, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for the services render to me by AMHFMC.

PATIENT SIGNATURE:____________________DATE: ______________

Arbor Mental Health & Family Medical Center
CONSENT TO TREATMENT

Patient Name:_______________________________________ **Acct. #:** ___________________

Date of Birth:________________________ **Date:** ___________________

1. I,______________________________(the_____________________of__________________________),
(Name of person giving consent) (Relationship, if other than patient) (Person to be treated)

   hereby voluntarily consent to outpatient care at Arbor Mental Health & Family Medical Center. encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking of X-ray, heart tracing and administration of medications prescribed by the provider.

2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, their assistants including provider' assistants or their designees as is necessary in the medical staff's judgement.

3. In consideration of services rendered, I hereby transfer and assign all right of payment due to me for medical and or surgical services under any policies of insurance.

4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the clinic.

5. This form has been fully explained to me and I understand its contents.

6. I give permission for diagnostic blood tests from me to be performed in case of an employee needle stick.

COMMENTS: ____

____

________________________________ ________________________________

Signature of Patient or Person Authorized to consent for patient

Signature of witness who explained the contents of this consent form (if applicable)

****

If patient is a minor or is unable to consent, complete A. OR B. below:

A. Patient is a minor and is______years of age.

Name of Father______________________________Name of Mother ______________________________

B. Patient is unable to consent because ____

____

___________________________ ______________ ______________________________

Signature of Closest Relative or Legal guardian

Relationship

Witness to representative's signature

Arbor Mental Health & Family Medical Center

Financial Policies

These policies were created by our provider to allow our office to run smoothly and efficiently. We are informing you of these policies so that there will be no misunderstandings that may harm our physician/ patient relationship. We understand that there may be extenuating circumstances which occur that may change the way we enforce these policies. Each occurrence will be handled on an individual basis.

Personal Information

In order to have current insurance, telephone numbers, addresses, current signature, etc., personal information and insurance information **must be updated every year**. You will also be asked for your insurance cards/drivers license, so that we may copy or scan them. A personal photo will be taken of you at your first visit. The photo is for security purposes and is required of ALL patients.

Payment due at time of service

Insurance copays are due **before** you see the provider for your visit. If you have a deductible, percentage, or no insurance, you will need to return to the front desk after the visit and the receptionist will calculate the amount due. If you come to your visit with no means of payment, you may still see the provider with his consent, and a $10 billing fee will be added to your account. It is your responsibility to keep us apprised of your new copay amount. If we have to bill you for a portion of your copay, we will add a $10 billing fee to your account. We take VISA, MC, DISCOVER, check, money order and cash.

Late Cancellations and No shows

You must cancel or reschedule your appointment within 24 hours of the appointment time. If you fail to do this, we will charge you a $25 fee. Multiple no shows or late cancellations may lead to termination.

Responsibility

You are responsible for all the charges owed to Arbor Mental Health & Family Medical Center as a result of professional services rendered, regardless of insurance coverage. If you have insurance, and we participate with your insurance plan, we will file to a primary and a secondary. If there is a balance on your account after your primary and secondary insurances have paid, that balance is your responsibility. If you have a tertiary insurance, you will have to file to that insurance company yourself and have them reimburse you. Should there be a dispute between you and your insurance company, we will not be responsible for collecting or negotiating claims.

Insufficient Funds Checks

Any checks returned to us for insufficient funds will be assessed a $25 fee. Checks will not be accepted from you for future payments.

Billing

We will bill you for any balance remaining after your insurance pays. If you think a mistake has been made, please call our billing department as soon as possible. If your balance due is not paid within 60 days of your first statement we will charge a $10 billing fee.

Acknowledgement

I have read and understand this statement of Financial Policies. All questions that I had have been answered.

____________________________________ ______________________
Signature of patient or responsible party Date

____________________________________ ______________________
Printed Name Account Number

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name____Medical Record ________________________

Date of Birth________________________________ Social Security #: ________________________________

I authorize the following individual or organization to disclose the above-named individual's health Information:

____Address:____

____Address:____

____Address:____

____Address:____

This information may be disclosed TO and used by: ***Arbor Mental Health & Family Medical Center***
6326 Sovereign Dr, Ste 601, San Antonio, TX 78229.

For the purpose of: ____

Please release the following:

- ⌋ Complete Record
- ⌋ Records of care from the following dates:______________________to______________________
- ⌋ Records concerning the following conditions: ____
- ⌋ Other, please specify: ____
- ⌋ Confer with the person(s) listed about my medical information: ______________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for AMHFMC.

____ ________________________
Signature of Patient or Legal Representative Date

____ ________________________
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and noted that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold SAPDM liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____ ________________________
Signature of Patient or Legal Representative Date

____ ________________________
Relationship to Patient (If Legal Representative) Witness

Arbor Mental Health & Family Medical Center
6326 Sovereign Dr, Suite 601, San Antonio, TX 78229
(726) 208-7900 FAX (726) 208-2200

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

1. We have a legal, ethical and moral obligation to protect your confidentiality. Any information about you and/or your family will be held strictly confidential by all employees. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner.

2. In order to provide quality care to you, as well as operate this office in an efficient manner, we will need to access your private health care information for purposes of treatment, payment and operations [such as quality assurance]. In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ["HIPAA"].

3. Specifically, we will need to disclose your private information under the following circumstances:

   a) **Sharing Information for Purposes of Treatment:** We will share information with all members of your treatment team, both within this office and with other providers [personal and institutional] in order to provide you with quality care and the educational/wellness programs specified in your insurance plan.

   b) **Sharing of Information for Purposes of Payment:** We will share all necessary information with your insurer[s], payor[s], governmental entities [such as Medicare, Medicaid, etc.] and their representatives [including, but not limited to benefit determination and utilization review] as well as our representatives involved in the billing process [including, but not limited to claims representatives and billing companies].

   c) **Sharing of Information for Purposes of Operations:** We will share all information necessary for ongoing operations of this office, including [but not limited to] credentialing processes, peer review, accreditation and compliance with all federal and state laws.

4. Your consent for use and disclosure of information as described may be revoked in writing at anytime. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

5. Your specific authorization will be required for the release of any information not included above unless disclosure is required by law, a court, a legal process or government agencies. Your authorization will need to be in writing and it will be specific to the disclosure requested. Incidences which will require your authorization under the HIPAA regulations include [but are not limited to] some marketing purposes, the disclosure of any psychotherapy records in our possession and disclosure for fundraising by any entity.

6. With the HIPAA privacy, you have the right to inspect and copy your protected information, amend your record, have reasonable requests for confidential communications accommodated and to obtain an accounting of disclosures. All other rights afforded to you by the state and federal law will be honored as they are created. Please contact the Privacy Officer if you have any question about your rights, the compliance date[s] for this office or any other privacy related questions you may have.

7. This office has policies and procedures in place to facilitate compliance with the law, as well as assure that this office consistently treats you with respect for you and your privacy and confidentiality. These policies and procedures are available for you to review. If you would like to read them, please notify the Privacy Officer.

8. The Privacy Officer is the person in the office responsible for your privacy and the security of your information. Any complaints you or your family may have in this area should be directed to the Privacy Officer. The front office staff will assist you in contacting them.

9. Release Authorizations: Certain disclosures and uses of patient information require authorization from the patient. These disclosures include: psychotherapy notes, protected information the office uses for marketing and any disclosure the office makes that constitutes a sale of the protected information.

10. Fundraising: Patient may opt-out of getting fundraising communications from this office.

11. Restricting Information Releases: Patients who pay for services in full and out-of-pocket may request our office not disclose any information about that service to their insurance company. This request must be in writing and must state what information is restricted and which insurance company should not receive it.

12. Breach Notification: Patients will be notified, in writing, when a breach in their protected information occurs.

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Dear Patient:

Providers have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by provider, hospitals, other health care providers and health plans. Provider now have to comply with the HIPPA privacy rule standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital or other health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask your physician or our Privacy Officer about exercising your rights or how your health information is protected in our office.

The Notice of Private Practices attached to this letter explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Privacy Officer at 726-208-7900, or discuss any questions you may have with your provider.

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Patient Consent for the Disclosure of Information

I have received a copy of the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

a) **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan.

b) **Sharing Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives including (but not limited to) claims representatives, data warehouses, billing companies, and collection agencies.

c) **Sharing Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible. I understand that it is standard office procedure to use voicemail, faxes, etc.

____________________________________ ______________________
Patient's Printed Name Date

____
Patient's Signature (or guardian if minor)

____________________________________ ______________________
Witness (optional) Date

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Authorization to Disclose Information to Family Members/Friends

I, the undersigned, authorize the provider and employees of Arbor Mental Health & Family Medical Center to discuss any and all of my medical and financial information with the following people/entities:

Name	Relationship	Phone number
______________________	______________________	__________________________
______________________	______________________	__________________________
______________________	______________________	__________________________

I understand that I have the right to revoke or terminate this authorization by submitting a written revocation to the office manager for Arbor Mental Health & Family Medical Center I understand that the information discussed under this authorization may be disclosed again by the person or organizations to which it is released. The privacy of this information may not be protected under federal privacy regulations.

Patient/Guardian Signature ____

Printed Name __________________________________

Date of Birth ________________________

Date __________________________

Patient Consent for Use of Email Communications

Arbor Mental Health & Family Medical Center

6326 Sovereign Dr, Suite 601, San Antonio, TX 78229

(726) 208-7900 FAX (726) 208-2200

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at the address provided by your providers office. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate**.

When sending email, you should put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your provider, my staff and/or colleagues would have access to this information.

PREFERRED EMAIL ADDRESS:__________________________@________________________

(please write clearly and legibly, use all small letters)

Please use the following for: zero=> Ø, number one=> 1, the letter after K=> l, lower case “eye” with a dot=> i

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office’s control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

______________________________ ______________________________

Patient signature Witness (optional)

____

Date

Arbor Mental Health & Family Medical Center

Dear Patient:

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. Our **Patient Portal** enables our patients to communicate with our providers, nurses, and staff members easily, safely, and securely *via* the Internet. Our **Patient Portal** is powered by eClinicalWorks—a national leader in electronic medical records.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the **Patient Portal**, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals (please use the pharmacy electronic refill request first)
- cancel or request appointments
- view parts of your personal health record
- examine your current and past statements
- receive appointment reminders by email

… all from the comfort of your home, whenever it is convenient for you!

By using the **Patient Portal**, you no longer have to call the office, leave a message, and wait for a response to get the results of your lab work; those results will be available to you through the Portal. You can also send a message to the office through the Portal. We will typically reply within 72 hours.

To learn more or to sign up--contact our office and follow the simple directions to register.

PORTAL DO's AND DON'T's ~~~~~~~~~~~~~~~~~~~~~~~~~~

Once you begin using the patient portal please consider and note the following:

- Add a **bookmark or favorite** to your preferred web browser.
- Remember, your password is **case sensitive**.
- You **cannot REPLY TO** any emails you receive, the address is not functional.
- Please log out when you are done with the portal--this will prevent forced password resets
- You may need to add our email address to your list of allowed email addresses (**AND/OR** to your contacts or address book), in order to **prevent messages from going to AMHFMC**. Add the following email address - **reminders@eclinicalmail.com**.
- You **CAN NOT use autofill** for your Portal password
- You will be locked out after 5 failed password attempts.
- If your email address should change, please let us know immediately.
- We do not have any way to support this site. Please remember or keep a record of BOTH your user ID and password for future use.
- **Alternate portal links** are:

HEALOW is a new app available on your iPhone of android phone (June 2013). Healow will link your smart phone to the patient portal. You MUST register online with the Patient Portal BEFORE using Healow. More information can be obtained at healow.com. The app is available at the iPhone app store and google play.

Visit healow.com for more information.

Stay in control of your healthcare with healow!

Now you can securely access your Patient Portal account and manage your family's healthcare with the healow App or your smartphone anytime. anywhere.

QR scan to download Android app

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What are you waiting for?

Access your Patient Portal account using healow and get secure, anytime, anywhere access to your important health information!

Visit **healow.com** & download the FREE app for your iPhone® or Android® smartphone today.

Scan QR code with any QR reader available on your smartphone to download healow.