Lomibao
RHEUMATOLOGY & WELLNESS CARE

☐ I am the patient completing these forms.

☐ I am filling this out on behalf of the patient. Name_____ Relation_____

Patient Information

Last_____ First_____ M_____

DOB_____/_____/_____ Sex: Female Male SSN _____-_____-_____

Cell Phone_____ Home Phone ☐ no ☐ yes_____

Email_____

Address_____
Street City State Zip

Emergency/Alternate Contact

Last_____ First_____ M_____

Relation_____ Phone_____ Email_____

Employed ☐ Yes ☐ No - Reason_____

Name of Employer_____ Phone_____

Address_____
Street City State Zip

Primary Insurance ☐ Yes - upload front & back of card ☐ No - I do not use insurance

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

Primary Insured ☐ same as patient ☐ someone else

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Secondary Insurance ☐ Yes - upload front & back of card ☐ No

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

Secondary Insured ☐ same as patient ☐ same as primary insured

Referring Doctor ☐ Yes ☐ No - I am self-referred. How did you hear about us?_____

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Primary Care Doctor ☐ same as referring doctor ☐ someone else ☐ I do not have a PCP/OBGYN

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Local

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Mail Order ☐ Yes ☐ No

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Demographics - Please select one of each of the following:

Marital Status	Race	Ethnicity	Language
Annulled	American Indian/Alaskan Native	Declined to specify	English
Divorced	Asian	Hispanic or Latino	Other
Domestic Partner	Black or African-American	Not Hispanic or Latino	Spanish
Legally Separated	Declined to specify	Other	
Married	Multiracial more than one race		
Single	Native Hawaiian or Other Pacific Islander		
Widowed	White		

Patient Preference Regarding Communication of Personal Health Information

☐ I do not wish to grant permission for any individual(s) to have access to any information regarding my medical condition(s).

☐ I do hereby grant permission for Lomibao Rheumatology & Wellness Care, PLLC to disclose and discuss any information related to my medical condition(s) with the following individual(s), if requested by said individual(s):

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Financial Policy, Billing Procedures, Card on File Policy

Insurance & Billing Procedures:
Lomibao Rheumatology & Wellness Care, PLLC ("the practice") is participating with Medicare and many commercial insurances. If you have coverage with Medicare and/or one of the commercial insurance carriers that we participate in, we will file your claim directly to your insurance carrier or Medicare for reimbursement. The practice's participation with insurance carriers is subject to change without notice.

As a courtesy, the practice will contact your insurance carrier to verify your benefits and/or necessary authorizations prior to your visit. Please be aware, this is only "a QUOTE of Benefits/Authorizations." **The practice cannot guarantee that your insurance carrier will provide us accurate or complete information regarding in or out of network status, reimbursement, or verify that definite eligibility of benefits.** Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service. **In the event that YOUR INSURANCE PROVIDER DOES NOT COVER services rendered for any reason, YOU WILL STILL REMAIN RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED.**

If your insurance carrier requires you to have a referral from your PCP, it is your responsibility to ensure that the referral information and referral number is received by this office from your PCP prior to your visit.

We accept all major credit cards, FSA/HSA cards, Apple Pay, Google Pay, electronic check, cash, personal checks. **Payment IN FULL of all estimated out-of-pocket expenses (co-pays, deductible, co-insurance, etc.) is REQUIRED AT THE TIME OF SERVICE AT CHECK-IN.** Please come prepared to make payment of these amounts. Your insurance policy is a contract between you and your insurance carrier. The ultimate responsibility for payment of services rendered rests with you, the patient or guarantor. **There is a $30 declined transaction/returned check fee for every declined transaction/returned check.**

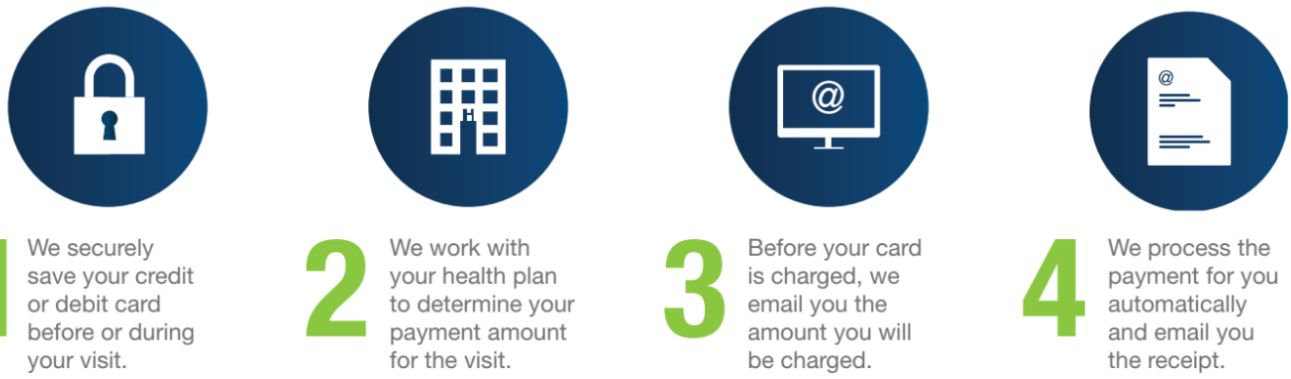
If we are not in your insurance network or if you have no insurance, we will expect payment in full at the time of service. **All pricing is subject to change without notice**, thus please contact our office for our current fee schedule prior to all visits so that you are prepared to make payment in full of these amounts.

Lomibao Rheumatology & Wellness Care, PLLC is **NOT A MEDICAID participating** provider and **DOES NOT DO WORKER'S COMPENSATION cases and DOES NOT FILL OUT DISABILITY FORMS of any kind.**

Card On File & Autopay - A Better Billing Experience for You:
We have implemented a billing policy in order to deliver a more convenient and consistent payment experience to our patients. **Our policy requires a card to be held on file for all patients. To avoid any issues of discrimination or favoritism; all patients who receive care at our practice are required to have a card on file regardless of insurance, private pay, or visit type. To simplify the process even further, we are enrolling patients with Autopay.** Card On File is the new standard in the healthcare industry nationwide, and soon all high quality medical practices will adopt it. This is the same process as reserving a hotel or renting a car.

Our practice is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. The card on file system drives down administrative costs as we will now spend less time entering card information for each transaction. We then have less paper statements to mail, which saves trees, money and time. Once your card is in the system, check-in and check-out time is much shorter for you as well. Additionally, when we are working remotely and seeing patients for virtual telemedicine visits, it is used to process charges since we are not on-site at the office to use our swipe machine. For insurance patients, the purpose of card on file is to cover any remaining balance due after insurance benefits are applied.

Here's how it works:



Q: How much are you going to charge my card on file?

A: You will be charged the amount that your insurance plan determines is your responsibility, after the insurance benefit has been applied.

Q: Will you send me a statement to let me know what I owe?

A: After your appointment, you will receive an explanation of benefits (EOB) from your insurance company that confirms your patient responsibility. We receive the same letter within 7-30 days following your appointment. We will review each EOB carefully and charge your card the amount that is determined by your health plan to be your responsibility, using autopay. You will receive an email/text notification 7 days before your card is charged, and on the day of the charge.

Q: What happens if I do not have a credit or debit card?

A: If you do not have a credit or debit card, we can accept a $250 deposit at check-in before your appointment.

Q: What happens if I need to dispute my bill?

A: You will only be charged the amount determined by your health plan in your EOB. However we will work with you if there has been a mistake on your bill.

Q: I do not have a deductible and/or I have dual plans. I will never owe anything. Do I still need to give you a card?

A: Due to the complexity of health plans, patients are not always aware of a payment responsibility. Additionally, changes to health plans happen often, which can make you responsible for payments without your knowledge. So we are requiring all patients to save a card on file to ensure we are prepared in the event they do have a payment responsibility.

Q: I've always paid my bills on time. Why do I have to give you a card?

A: To be fair and consistent to all of our patients, we are implementing the policy to all patients who seek care at our practice. Additionally, we want all of our patients to benefit from this simplified way to pay medical bills. This is the same process as checking in at a hotel or renting a car.

We are committed to security, which is why we exclusively use HIPAA compliant encrypted card processor called InstaMed, which is a JP Morgan Chase bank subsidiary that exclusively handles medical industry transactions. The practice securely stores credit and debit cards on file with InstaMed to streamline processes working with patients, as described above. Your card is NOT charged when it is added to the platform, only when there is a patient responsibility that is owed.

7700 Lakeview Pkwy Suite 300A Rowlett, TX 75088
Phone: 469.825.4010 Fax: 469.825.4020
Last updated 1/10/2022

InstaMed is healthcare's most trusted payments network, and unmatched when it comes to security and compliance. InstaMed is a Payment Card Industry Data Security Standard (PCI DSS) Level One v3.2 Service Provider, as well as EMV and HITRUST certified. InstaMed was the first in healthcare to be PCI-validated for P2PE v2.0, which is a methodology for securing credit card data by encrypting it from the time a card is swiped or keyed until it reaches a secure endpoint (InstaMed) where it is decrypted.
For more information: https://www.instamed.com/compliance-and-security/

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the above.

Patient Signature **Date**

Appointment Confirmation Policies

Appointment Confirmation:
You will receive a text/phone reminder **one (1) week and two (2) days prior** to your scheduled appointment. It is **imperative to confirm that you are coming to your appointment**, or your appointment time may be offered to another patient.

New Patient Preparation:
Please review how to prepare for your first appointment in the FAQ section of our website lomibaorheumatology.com.

Arrival to Clinic:
We request that **new patients arrive twenty (20) minutes prior** to appointment time and **established patients arrive ten (10) minutes prior** to appointment time, to allow for any unforeseen issues such as insurance verification, address change, etc. to be addressed at check-in. This will also enable you to have enough time to be triaged by the Medical Assistant (MA) to then start your visit with the doctor at the start of your appointment time.

Late Arrivals:
In order to provide the best care possible for all patients, we do strive to run the clinic in a timely fashion and respect your time, and we ask that you do the same. We **reserve the right to reschedule** an appointment if a patient arrives (ie. standing at the check-in window) 10 or more minutes late for a new patient appointment, or 5 or more minutes late for a follow-up appointment. We strive to be fair to those who showed up early and on time.

Cancellations/Rescheduling & No Show's:
If you are unable to come for your appointment for any reason, we must have **24 business hours** in advance of the cancellation/rescheduling. (Note that we are closed Thanksgiving Day, Christmas Day, New Years Day, Memorial Day, Independence Day, Labor Day, so these do not count as a business day.) For example, you must provide notice on a Friday at 9AM to cancel for a Monday 9AM appointment. This is the fairest way to allow another patient the chance to be offered your appointment time.

Failure to provide this advance notice as described above and those who do not show up for their appointment will incur a **No Show Fee for $100 for New Patient and $50 for Established Patient** as this is time lost that another patient could have used. No Show fees are not reimbursable through insurance, and subject to change without notice. ***No Show fees WILL NOT BE REFUNDED for any reason, as this is a non-recoverable loss of appointment time that would have been offered to another patient.***

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the above.

_____ _____

Patient Signature **Date**

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Consent to Receive Medical Care

I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC and any employee working under direction of the physician to provide medical care for me. This medical care may include services and supplies related to my health and may include but not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

_____ _____

Patient Signature **Date**

Consent for Telemedicine

☐ I do not wish to be offered telemedicine

☐ I would like to be offered telemedicine

1. I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC to use the telemedicine practice platform for audio/video communication for evaluating, testing and diagnosing my medical condition(s).

2. I understand that it is **my responsibility to set up and learn how to use the telemedicine system *prior* to my scheduled appointment time.**

3. I understand that technical difficulties may occur before or during the telemedicine sessions and my appointment cannot be started or ended as intended.

4. I understand that my current insurance may not cover the fees for telemedicine practices and I may be responsible for any fee that my insurance company does not cover for this service.

_____ _____

Patient Signature **Date**

COVID-19 Risk Patient Informed Consent and Acknowledgment

The novel coronavirus (COVID-19) has been declared a worldwide pandemic by the World Health Organization. Lomibao Rheumatology & Wellness Care, PLLC ("the practice") is taking measures to comply with federal, state, and Centers for Disease Control (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, but we cannot make any guarantees about your health and safety. Therefore, to proceed with your treatment with the practice, please read the below and indicate your agreement by signing.

Informed Consent
I understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing.

I recognize that: (i) the practice has implemented reasonable preventative measures aimed to help reduce the spread of COVID-19; (ii) to the practice's knowledge, its providers and employees at this location have acknowledged that they don't have symptoms of COVID-19; and (iii) because the practice provides healthcare services, other persons (including other patients) could be infected, with or without the practice's knowledge, that may have been on the practice's premises.

Therefore, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with my treatment. I understand that possible exposure to COVID-19 during my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, short-term or long-term intubation, other potential complications, and the risk of death. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein. I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19.

By signing below, I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment visit, and I give express consent for my Lomibao Rheumatology & Wellness Care, PLLC provider and staff at this location to proceed with treating me.

I represent that I have been practicing all current CDC guidelines with respect to "social distancing," and, to my knowledge, I neither have symptoms of COVID-19, have COVID-19, nor have I been in contact with a person who has tested positive for, or who is suspected to be positive for, COVID-19.

By signing below, I hereby acknowledge and represent that I have: (i) been informed by Lomibao Rheumatology & Wellness Care, PLLC of its desire to protect its patients, staff, and the community at large; and (ii) been given the option to defer my appointment to a later date.

_____ _____

Patient Signature **Date**

CDC Notice COVID-19 Screening

1.	Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea o vomiting, diarrhea?	**YES**	**NO**
2.	Within the past 14 days, have you been in close physical contact (6 feet or closer for a least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
3.	Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
4.	Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

Emergency Room & Specialty Care Only Disclaimer

For urgent medical situations and emergencies we advise you to go to the nearest emergency room and/or to call 911. There is no overnight, weekend, holiday call coverage, and there is no call coverage whenever the office is closed for any other reasons, thus **all incoming communications received after business hours will be returned the next business day,** including but not limited to phone calls, voicemails, portal messages, emails etc.

- **PLEASE CALL 911 AND REPORT TO THE NEAREST EMERGENCY ROOM IF YOU ARE HAVING A PROBLEM AND OUR OFFICE IS CLOSED.**

The scope of practice of Lomibao Rheumatology & Wellness Care, PLLC is limited to Rheumatology Specialist practice ONLY and we reserve the right to define our scope of practice.

- We expect all patients to have their own Primary Care Provider (PCP) and will refer you to your **PCP to handle ALL NON-RHEUMATOLOGY complaints/refills/lab orders/problems.**
- If you **do not have a PCP** you will be referred to an **Urgent Care or ER to handle ALL NON-RHEUMATOLOGY complaints/refills/lab orders/problems.**

Forms Fees & Medical Records Copies Fees

If clinically warranted and agreeable, the providers at Lomibao Rheumatology & Wellness Care, PLLC will review and sign FMLA forms/work forms or letters, and Parking Placard forms. **We reserve the right to define what is considered a "work form" or "work letter" and collect fees each time they are requested.**

- The fee for each time FMLA forms/work forms/letters are filled out is **$40.**
- The fee for each time Parking Placard forms are filled out is **$20.**

These fees are not reimbursable by insurance and collected upon request of forms to be filled out, pricing subject to change without notice. It is the patient's responsibility to bring a paper copy of the forms they want filled out each time. **WE DO NOT FILL OUT FORMS/LETTERS ON DEMAND - please plan for up to five (5) business days for form/letter completion upon request.**

Lomibao Rheumatology & Wellness Care, PLLC **DOES NOT FILL OUT DISABILITY FORMS** of any kind or get involved in the legal intricacies of Disability of any kind. If you need your medical records to support a Disability claim that is being handled by another provider, or for any reason, we will provide you with copies upon request.

- The fee for providing patients with paper copies of medical records is **$25 for the first twenty pages** and **$0.50 per page for every copy thereafter.**
- The fee for providing patients with copies of medical records in electronic format is **$25 for 500 pages or less** and **$50 for more than 500 pages.**

Medication Refill & Controlled Substance/Psychoactive Drugs Policies

In order to provide the best care possible, please always come prepared to your appointment with your list of medications you need refilled. Otherwise, please contact your pharmacy regarding refills. Lomibao Rheumatology & Wellness Care, PLLC **does not send routine refills when the office is closed** such as after hours, weekends, or holidays. It is your responsibility to come prepared to your appointment with your refill list.

Lomibao Rheumatology & Wellness Care, PLLC is **strictly a no-narcotic, no-psychoactive drugs, and no-controlled substance practice**, this includes but is not limited to:

1. DEA Schedule II Narcotics such as: hydromorphone (Dilaudid), methadone (Dolophine), meperidine (Demerol), oxycodone (OxyContin, Percocet), and fentanyl (Sublimaze, Duragesic), morphine, opium, codeine, and hydrocodone, (Tylenol with Codeine), (Robitussin AC, Phenergan with Codeine) and buprenorphine (Suboxone).
2. DEA Schedule II Stimulants such as: amphetamine (Dexedrine, Adderall), methamphetamine (Desoxyn), and methylphenidate (Ritalin).
3. DEA Schedule III others such as: benzphetamine (Didrex), phendimetrazine, ketamine, and anabolic steroids such as Depo-Testosterone.
4. DEA Schedule IV Depressants such as: tramadol (Ultram), alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam (Halcion).
5. DEA Schedule V anti-seizure drugs such as: gabapentin (Neurontin), pregabalin (Lyrica).
6. Psychoactive drugs Antidepressants and Antianxiolytics such as: Fluoxetine (Prozac), Paroxetine (Paxil, Seroxat), Citalopram (Celexa), Escitalopram (Lexapro), Sertraline (Zoloft), Duloxetine (Cymbalta), Milnacipran (Savella), Venlafaxine (Effexor), Bupropion (Wellbutrin), Mirtazapine (Remeron), Isocarboxazid (Marplan), Phenelzine (Nardil), Tranylcypromine (Parnate), Amitriptyline (Elavil).

TEXAS MEDICAL BOARD NOTICE

NOTICE CONCERNING COMPLAINTS Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018 Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353 For more information please visit the website at www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas: Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018 Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353 Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us

HIPAA NOTICE OF PRIVACY PRACTICES

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

YOUR RIGHTS
When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you. Please contact the Privacy Officer (referenced at the end of this notice) to exercise these rights.

Obtain an electronic or paper copy of your medical record.
You may ask to see or obtain an electronic or paper copy of your medical record and other health information. If requested, we will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record.
You may ask us to amend health information about you that you think is incorrect or incomplete. We have the right to deny your request, but we will explain in writing within 60 days of your request.

Request confidential communications.
You may ask us to contact you in a specific confidential manner (for example, home or office phone) or to send mail to a different address. We will comply with reasonable requests.

Ask us to restrict what we use or share.
You may ask us not to use or disclose certain health information for treatment, payment, or our health care operations. We are not required to agree to your request, and we may decline if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, and if the information is to be disclosed for payment or healthcare operations, you may ask us not to share that information with your health insurer. We will agree to this request unless a law requires us to share that information.

Obtain a list of those with whom we've shared information.

You may ask for a list (accounting) of the times we've shared your health information, with whom we've shared it, and why, for one year prior to the date you make the request. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Choose someone to act for you.
If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
You may complain if you feel your privacy rights have been violated by contacting us using the information on the last page. Alternatively, you may file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

YOUR CHOICES
For certain health information, you may tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please indicate your preferences.

We may use or disclose your health information in the following instances, provided you are informed in advance and you do not object:
For purposes of sharing your information with your family, close friends, or others involved in your care.
For purposes of sharing your information to assist in disaster relief efforts.

We may NOT use or disclose your health information in the following instances unless we obtain your written authorization:
For purposes of marketing.
For purposes of selling your information.
For purposes of disclosing highly sensitive information that pertains to psychotherapy, mental health, and alcohol, and drug treatment, sexually transmitted diseases, child abuse, genetics, and other highly confidential and sensitive characteristics.
For purposes of other uses and disclosures not described in this notice.

You may revoke an authorization at any time, provided that the revocation is in writing, except to the extent that (i) we have taken action in reliance on the authorization; or (ii) if the authorization was obtained as a condition of obtaining insurance coverage.

OUR USES AND DISCLOSURES
How do we typically use or share your health information? We are permitted to use or disclose your health information for treatment, health care operations or payment. In particular, we typically use or disclose your health information in the following ways:

Treatment.
We may use your health information and share it with other professionals who are providing you medical treatment.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Business Operations.
We may use and disclose your health information for our health care operations to manage our business and the services we provide to you.

Example: We use health information to conduct quality assessment and improvement activities.

Billing for your services.
We may use and disclose your health information to bill and get payment.
Example: We provide information about you to your health insurance company and other entities so they will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many legal requirements before we can share your information for these purposes.

Help with public health and safety issues.
We can share information about you for certain situations such as:
Preventing disease
Helping with product recalls
Reporting adverse reactions to medications
Reporting suspected abuse, neglect, or domestic violence
Preventing or reducing a serious threat to anyone's health or safety
Conduct Research
We may use or disclose your information for health research only with your written permission.

Comply with the law.
We will disclose information about you if State or Federal laws require it, including Department of Health and Human Services, requesting proof of compliance with federal privacy and security laws.

Respond to organ and tissue donation requests.
We may disclose health information about you with organ procurement organizations upon your passing.

Work with a medical examiner or funeral director.
We may disclose health information with a coroner, medical examiner, or funeral director in the event of death.

Address law enforcement, and other government requests.
We may use or disclose health information about you:

For law enforcement purposes or with a law enforcement official.
With health oversight agencies for activities authorized by law.
For special government functions, such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions

We may share health information about you in response to a court or administrative order, or in response to a subpoena.

Telehealth.
We may disclose your health information with Lomibao Rheumatology & Wellness Care, PLLC providers through the use of telehealth. Telehealth involves the use of electronic communications via live two-way audio and video that is intended to improve patient care through efficient medical evaluations and management.

Electronic Communication.

We may disclose your health information in electronic communications which are (a) in our text messages, emails or other electronic communications to you or in response to text messages, emails or electronic communications from you to us; and (b) statements or inquiries that you have posted on our web page, Twitter page, Facebook page, Instagram, or other public domains. Please note that the transmission and/or storage of text messages, emails, social media postings, and other electronic communications may not be encrypted or secure. If you have a specific question regarding your medical condition, we encourage you to contact us directly to discuss.

Electronic Disclosures.
Lomibao Rheumatology & Wellness Care, PLLC is providing you with notice that your health information may be subject to electronic disclosure. Lomibao Rheumatology & Wellness Care, PLLC may not electronically disclose your health information to any person without your authorization, which may be obtained electronically, in writing, or in oral form if it is documented by Lomibao Rheumatology & Wellness Care, PLLC. However, such authorization is not required for an electronic disclosure of health information if the disclosure is made: (i) to another health care provider, health plan, or covered entity as defined under Texas law for the purpose of: (a) treatment; (b) payment; (c) health care operations; or (d) performing an insurance or health maintenance organization function; or (ii) as otherwise authorized or required by state or federal law.

OUR RESPONSIBILITIES
We are required by law to maintain the privacy and security of your protected health information in compliance with federal and state law. We are required to notify you of this duty and of our privacy practices with respect to your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your unsecured information.

We must follow the duties and privacy practices described in this notice and provide you a copy of it. We will not use or disclose your information other than as described here unless you provide us written permission.

Changes to the Terms of This Notice.
We may change the terms of this notice, and the changes will apply to all protected health information we maintain. The new notice will be available on our website and upon request in our offices.

You may contact Lomibao Rheumatology & Wellness Care, PLLC's Privacy Officer Frances Lomibao, MD at: Lomibao Rheumatology & Wellness Care, PLLC, 7700 Lakeview Pkwy Suite 300A, Rowlett, TX 75088.

The Effective Date of this notice 9/21/2020.

By signing below, I acknowledge that I have received, reviewed, and understand the HIPAA Notice of Privacy Practices (“HIPAA Notice”) on behalf of the Lomibao Rheumatology & Wellness Care, PLLC. I acknowledge that the HIPAA Notice describes Lomibao Rheumatology & Wellness Care, PLLC’s policies and procedures regarding the use and disclosure of my protected health information created, received, transmitted, and maintained by the Lomibao Rheumatology & Wellness Care, PLLC.

In addition, by signing below, I acknowledge and agree to authorize the Lomibao Rheumatology & Wellness Care, PLLC to communicate the Notice via e-mail and my health information through the use of phone, voicemail, e-mail, text message, electronic communications, telehealth technology, and personal communication as well as including electronic communication for announcements, newsletters, or other similar purposes as permitted under applicable law.

ACKNOWLEDGEMENT OF RECEIPT OF

Emergency Room & Specialty Care Only Disclaimer

Forms Fees & Medical Records Copies Fees

Medication Refill & Controlled Substance/Psychoactive Drugs Policies

Texas Medical Board Notice

HIPAA Notice of Privacy Practices

By signing below, I hereby acknowledge that I have received, read, reviewed, understand and agree to all of the above Policies and Notices of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

Patient Signature **Date**