Concentra®

Employer Services Patient Information

Improve the health of America's workforce, one patient at a time.

Please complete packet and email back to Concentra @:
To: Alena_McAbee@concentra.com
cc: Manuel_Tristan@Concentra.com

Due by:___/___/____

Reason for Today's Visit

☐ Injury Care ☐ Physical exam ☐ DOT (CDL) Certification

☐ Drug Screen ☐ Other:_____

About You

Social Security # or Military DBN:_____ Date of birth (MM/DD/YYYY):_____

Last name:_____ First name:_____ M.I.:_____

Address:_____ Apt. #:_____ City:_____ ST:_____ ZIP:_____

Home phone:_____ Work phone:_____

Cell phone:_____ ☐ Male ☐ Female ☐ Single ☐ Married

Email address:_____ Concentra may send a detailed email: ☐ Yes ☐ No

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

About Your Employer

Employer Requesting Services

Company name: Sam Houston State University Location/store number: N/A

Address: Box 2448 Ste. #:_____ City: Huntsville ST: TX ZIP: 77341

Is your employment arranged through a temporary hire agency? ☐ No ☐ Yes

Name of agency: N/A Agency phone: N/A

Notice of Privacy Practices

Your name and signature below indicates that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy office at 800-819-5571 or privacyoffice@Concentra.com.

Name: (please print)_____ Date Notice Received:_____

Signature:_____ Date:_____

Consent (If you are here for a Department of Transportation drug screen or breath alcohol test ONLY, skip this section. For all other services, please complete.)

The information provided is correct to the best of my knowledge. I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature:_____ Date:_____

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs"); and (c) completion of medically appropriate tests for communicable and other diseases.

Signature: N/A Date: N/A

EMPLOYER SERVICES-AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) HIPAA RELEASE

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: _____ Birthdate: _____

Address: N/A

PURPOSE OF DISCLOSURE

☐ Occupational Injury ☐ Occupational Non-Injury ☐ Other

CONFIRMATION OF WHO MAY RECEIVE COPIES OF YOUR RECORDS

Employer or Entity Name: Sam Houston State University

Address: Box 2448 City: Huntsville State: TX Zip: 77341

Fax Number: - - Confirmation Telephone Number: - -936-294-4875

IN CONNECTION WITH THIS AUTHORIZATION:

• I am aware that copies of records for services rendered on _____(date of service) and subsequent related visits containing PHI which may include the results of tests or evaluations, including diagnosis, and medical history, transcription notes, and tests and evaluations performed that my employer, prospective employer or third party entity has ordered or requires.

• I give Concentra authorization to release to my employer, insurance company, and/or their representatives any medical information, including any psychotherapy notes,* psychiatric information, sexually transmitted diseases, alcohol and drug abuse and/or * HIV/AIDS status, which is obtained as part of the treatment for this work related injury/illness, or employment-related examination.

• I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

• I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.

• I understand that Concentra may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.

• I have a right to not sign this authorization or to limit the information I authorize to be disclosed to the minimum necessary, however, refusal to sign this authorization or to limit disclosure of my PHI may violate a condition of employment or prospective employment.

• I may revoke this authorization at any time, but I must do so by submitting a written notice to the Concentra center where I received services. However, if I am here for a work-related visit that is subject Workers' Compensation, under some state laws I am not allowed to revoke this authorization.

I have a right to receive a copy of this authorization.

_____ OR _____

Patient's Signature / Date: _____ Signature of Patient's Representative/Date: _____

_____ _____

Printed Name of Patient's Representative Explanation of your legal right to sign for Patient

For HIPAA questions related to this form, please contact the Privacy Office at 1-800-819-5571.

* I object to the release of psychiatric information, sexually transmitted diseases, alcohol and drug abuse, and/or HIV/AIDS status. I understand disclosure of this information will require me to sign a separate authorization. Patient Signature _____

Concentra
Notice of Privacy Practices

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

I. CONTACT PERSON. If you have any questions about this Notice of Privacy Practices (Notice), please contact us through one of the methods listed at the end of this Notice.

II. EFFECTIVE DATE OF THIS NOTICE. The original effective date of this Notice was April 26, 2003. The most recent revision date is at the end.

III. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). We are required by law to maintain the privacy of your personal information. This medical information is called protected health information or "PHI" for short. PHI includes information that can be used to identify you that we have created or received about your past, present, or future health or medical condition, the provision of health care to you, or the payment of this health care. We need access to your medical records to provide you with health care and to comply with certain legal requirements. This Notice applies to all of the records of the care and services you receive from us, whether made by our employees or your physician. This Notice will tell you about the ways in which we may use and disclose PHI about you and describes your rights and certain obligations we have regarding the use and disclosure of your PHI.

However, we reserve the right to change the terms of this Notice and our Privacy Policies and Procedures at any time. Any changes will apply to the PHI we already have. When we make a significant change in our privacy practices, we will change this notice and post when applicable or provide you a copy of the revised notice. You can also request a copy of this Notice from us at any time by contacting us using any of the methods described on the last page of this notice.

IV. OUR DUTIES. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this Notice of our privacy practices with respect to your PHI;
- disclose information on HIV, mental health, and/or communicable diseases only as permitted under federal and state law; and
- follow the terms of this Notice as long as it is currently in effect. If we revise this Notice, we will follow the terms of the revised Notice.

V. HOW WE MAY USE AND DISCLOSE YOUR PHI. The following categories (listed in bold-face print) describe different ways that we use and disclose your PHI. Disclosures of PHI may be provided in various media, including electronically. For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information about you will fall within one of the bold-face print categories. Also, not all of the categories may apply to the health care service you are seeking. For example, if your employer is paying for a service (pre-employment or biometric screening), then we would not release your information to the insurance carrier for payment.

A. For Treatment. We may disclose your PHI to physicians, nurses, case managers, and other health care personnel who provide you with health care services or are involved in your care. We may use and disclose your PHI to provide and coordinate the treatment, medications and services you receive including dispensing of prescription medications when applicable. For example, if you're being treated for a knee injury, we may disclose your PHI regarding this injury to a physical therapist or radiologist, or to medical equipment suppliers or case managers.

B. To Obtain Payment for Treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our Business Associates, such as billing companies and others that process our health care claims.

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

C. For Health Care Operations. We may disclose your PHI in order to operate our facilities. For example, we may use your PHI to evaluate the quality of health care services that you received, for utilization management activities, or to evaluate the performance of the health care professionals who provided the health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

D. To Business Associates for Treatment, Payment, and Health Care Operations. We may disclose PHI about you to one of our Business Associates in order to carry out treatment, payment, or health care operations. For example, we may disclose PHI about you to a company who bills insurance companies on our behalf so that company can help us obtain payment for the health care services we provide.

E. Individuals Involved in Your Care or Payment for Your Care. We may release PHI about you to a family member, other relative, or close personal friend who is directly involved in your medical care if the PHI released is relevant to such person's involvement with your care. We also may release information to someone who helps pay for your care. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your location and general condition.

We may release health or health-related information about you to your employer if we provide services at their request. If services are provided at your employer's location, please be aware that due to the nature of shared facilities and services, your employer may have access to your records. For example, this may occur with shared staff, storage, or technology.

F. Appointment Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or health care.

G. Treatment Alternatives. We may use and disclose PHI to give you information about treatment options or alternatives. We may contact you regarding compliance programs such as drug recommendations, drug utilization review, product recalls and therapeutic substitutions.

H. Health-Related Benefits and Services. We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

I. Workers' Compensation.* We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

J. Special Situations.*

1. As Required By Law.* We will disclose PHI about you when required to do so by federal, state, or local law, such as the Occupational Safety and Health Act (OSHA), Federal Drug Administration (FDA), or Department of Transportation (DOT).

2. Public Health Activities.* We may disclose PHI about you for public health activities. Public health activities generally include:

- **a.** preventing or controlling disease, injury or disability;
- **b.** reporting births and deaths;
- **c.** reporting child abuse or neglect;
- **d.** reporting reactions to medications or problems with products;
- **e.** notifying people of recalls of products;
- **f.** notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
- **g.** notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

3. Health Oversight Activities.* We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

4. Lawsuits and Disputes.* If you are involved in a lawsuit or a dispute, we may disclose PHI

about you under a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else in the dispute.

5. Law Enforcement.* We may release PHI if asked to do so by a law enforcement official:

a. in response to a court order, subpoena, warrant, summons or similar process;

b. to identify or locate a suspect, fugitive, material witness, or missing person, but only if limited information (*e.g.*, name and address, date and place of birth, social security number, blood type, RH factor, injury, date and time of treatment, and details of death) is disclosed;

c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

d. about a death we believe may be the result of criminal conduct;

e. about criminal conduct we believed occurred at our facility; and

f. in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

6. Coroners, Medical Examiners and Funeral Directors.* We may release PHI about patients to a coroner or medical examiner to identify a deceased person or to determine the cause of death or to funeral directors to carry out their duties.

7. Organ and Tissue Donation.* We may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation.

8. Research.* Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects are subject to a special approval process which requires an evaluation of the proposed research project and its use of PHI, and balances these research needs with our patients' need for privacy. Before we use or disclose PHI for research, the project generally will have been approved through this special approval process. However, this approval process is not required when we allow PHI about you to be reviewed by people who are preparing a research project and who want to look at information about patients with specific medical needs, so long as the PHI does not leave our facility.

9. To Avert a Serious Threat to Health or Safety.* We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat.

10. Armed Forces and Foreign Military Personnel.* If you are a member of the Armed Forces, we may release PHI as required by military command authorities or about foreign military personnel to the appropriate foreign military authority.

11. National Security and Intelligence Activities.* We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

12. Protective Services for the President and Others.* We may disclose PHI about you to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

13. Inmates.* If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary, for example, for the institution to provide you with health care; to protect your

health and safety or the health and safety of others; or for the safety and security of the correctional institution.

14. Food and Drug Administration (FDA).* We may use and disclose to the Food and Drug Administration (FDA), or person under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

K. Incidental Uses and Disclosures.* Uses and disclosures that occur incidentally with a use or disclosure described in this Notice are acceptable provided there are reasonable safeguards in place to limit such incidental uses and disclosures.

***In New Mexico and Pennsylvania, uses and disclosures other than those marked with an asterisk may require your written authorization.**

VI. WHAT DO WE DO WITH YOUR INFORMATION WHEN YOU ARE NO LONGER A PATIENT OR YOU DO NOT OBTAIN SERVICES THROUGH US? Your information may continue to be used for purposes described in this notice when you do not obtain services through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

VII. YOUR RIGHTS REGARDING YOUR PHI.

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to approve it. If we approve your request, we will put any limits in writing and follow them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations. We must comply as long as it is not for purposes of carrying out treatment; and the PHI pertains only to a health care service for which we have been paid out of pocket in full without the application of insurance benefits or discounts. If the payment is not honored, then we do not need to comply with the request if we need to seek payment.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you to an alternate address or via an alternate method. We must agree to your request so long as we can easily provide it in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI, but we know who does, we will tell you how to get it. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, there may be a per page charge. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to any additional costs in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI in the past six (6) years. The list will include the date of the disclosure(s), to whom PHI was disclosed, a description of the information disclosed, and the reason for the disclosure. The list will not include uses or disclosures that were made for the purposes of treatment, payment or health care operations, uses or disclosures that you authorized, or disclosures made directly to you or to your family. The list also will not include uses and disclosures made for national security purposes, or to corrections or law enforcement personnel. Your request must state a time period that may not be longer than six (6) years prior, but may certainly be less than six (6) years.

E. The Right to Correct or Update Your PHI. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment of the existing information or to add the missing information. You must provide the request and your reason for the request in writing. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI. We may deny your request if the PHI is: (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a statement of disagreement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI.

F. The Right to Get This Notice. You have the right to get a copy of this Notice in paper and by e-mail.

G. How Will My Information be Used for Purposes Not Described in This Notice? In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require authorization.

1. Most uses and disclosures of psychotherapy notes
2. Marketing purposes
3. Sale of protected health information

VIII. HOW TO REQUEST YOUR PRIVACY RIGHTS. If you believe your privacy has been violated in any way, you may file a complaint by contacting us as described below. We are committed to responding to your rights request in a timely manner. To request any of your privacy rights, please contact us:

- Call us at 1-800-819-5571 at any time
- Accessing our Website at www.concentra.com
- e-mailing us at privacyoffice(@,concentra.com
- Mail completed request form to:

Concentra Privacy Office
4714 Gettysburg Road
Mechanicsburg, PA 17055

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

We will respond to all privacy requests and complaints. It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situation where your information would be used for reasons other than what is listed above.

IX. What will happen if my private information is used or disclosed inappropriately? You have the right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

Date of Last Revision: February 1, 2018

C O N F I D E N T I A L

Academic Year:

Sam Houston State University
Occupational Health Evaluation

QUESTION: Who sees my personal medical information?
ANSWER: When you submit this completed form to Concentra Medical Center via encrypted email, it is treated with all the safeguards as any other medical record. Only the Occupational Health Physician at Concentra reviews this information.

PART I *(to be completed by the employee with assistance from the Director/Supervisor/Principal Investigator if needed)*

NAME **Last:** **First:** **MI:**

TODAY'S DATE **SHSU ID#**

GENDER ☐ FEMALE ☐ MALE DATE OF BIRTH

DATE OF LAST TETANUS VACCINATION: / / ☐ UNKNOWN ~ Call IACUC Office (x4875) for assistance in obtaining a vaccination.

CAMPUS ADDRESS PHONE

HOME ADDRESS PHONE

DEPARTMENT/UNIT PHONE

POSITION TITLE

SUPERVISOR PHONE

PERSONAL PHYSICIAN'S NAME PHONE

PHYSICIAN'S ADDRESS

PURPOSE: Certain drugs and medical conditions may place you at increased health risk in certain work environments that involve animal research. Such drugs and conditions include but are not limited to steroids, allergies, cancer, chronic diseases, pregnancy, surgical procedures, and absence of spleen, stress, and deficiencies of the immune system. This information is requested to benefit you and the Occupational Health physician, who reviews this form to recognize the health risks posed to you by animal research and to recommend ways to reduce those risks.

Personal medical information used to assess occupational risk is requested on the following page.

☐ **I agree to provide this information.**

Signature: **Date:**

☐ **I have read and understand the above section entitled 'Purpose' and I understand the confidentiality safeguards, but I decline to provide the information requested.**

Signature: **Date:**

PART II *(to be completed by the employee with assistance from the Director/Supervisor/Principal Investigator if needed)*

Check the appropriate response for each item below.

1. Do you have any allergies?

ENVIRONMENTAL:	TYPE OF REACTION: HIVES	RASH	DIFFICULTY BREATHING	ANAPHYLAXIS
Pollen	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
House Dust	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Mold	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Stinging Insects	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Animal Dander	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Latex	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Food	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Feathers	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Other:	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

If Other, please describe:

SIGN AND DATE PAGE 3 BEFORE SUBMISSION TO CONCENTRA.

PART III

OCCUPATIONAL PHYSICIAN USE ONLY

Assessment:_____

_____

_____

_____

_____

_____

_____

PART III OCCUPATIONAL PHYSICIAN USE ONLY

Recommendations:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____

Patient: **DOB:** **Service Date:**

Job Description

_____ Job description was provided by the employer and has been reviewed by the examining provider.

_____ Job description not available. Determination is based solely upon description of duties provided by the patient/applicant.

Examination Results for:

Exam Type: _____ **Standard Physical Examination** _____ **Medical Surveillance** _____ **Fit for Duty**

_____ May work without limitations/restrictions.

_____ May work only with the following limitations/restrictions: _____

_____ Unable to meet physical requirements of the job.

_____ Determination pending: additional information required. Requested information and/or additional evaluation must be completed within 45 days.

Remarks: **No protected health information (PHI)*

_____

_____

_____

_____
Clinician's Printed Name

_____
Clinician's Signature

**If status above listed as determination pending, please document status after review of additional records/testing:

_____ May work without limitations/restrictions

_____ May work only with the following limitations/restrictions: _____

_____ Unable to meet physical requirements of the job.

_____
Date Final Determination Made

_____
Clinician's Printed Name

_____
Clinician's Signature