PREFACE

Texas Medical Liability Trust is strongly committed to the prevention of professional liability claims in your medical practice. The TMLT Risk Management Department endeavors to present materials for physicians and their staffs to provide a foundation for basic risk management.

This manual has been developed as a guide for physicians, their administrators, and management staffs. The information contained herein is intended to enhance your knowledge of risk management, reduce your exposure to claims, and assist in defense should a claim occur.

The TMLT Risk Management Department is not an accrediting entity, nor are the guidelines intended to serve as legal advice.

The TMLT Risk Management Department is available to assist you and welcomes your calls or questions.

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I. GENERAL RISK MANAGEMENT GUIDELINES

In developing a risk management program for your office, several items need to be considered. Risk management is an overall philosophy for the entire office and is no longer solely represented by the individual Risk Manager or Quality Improvement Manager. The information contained in this manual is directed toward the physician and the administrative/management staff to develop a well-rounded risk management program.

Staff: hiring, orientation, and training

*Have employees sign a statement of confidentiality upon employment.*

- Physicians can be held legally responsible for breaches of confidentiality by their staffs. A confidentiality contract will place the responsibility upon the staff legally holding them to a higher standard due to the profession in which they are employed. They must never discuss patients with an inappropriate party or in an inappropriate setting. See Appendix 1 for a sample Employee Confidentiality Statement. Maintain a copy in the personnel file.

*Medical practices are responsible for ensuring that all employees are properly trained and/or credentialed.*

- Since physicians can be held legally responsible for the negligent acts of their employees and any contract workers under their direction, prospective employees should be screened by verification of their education, licensing and their previous employment history, including references from past employers.

- Even though potential employees may be known to your practice, you are encouraged to perform background checks and obtain references. Record keeping in this area illustrates an attitude of concern for the quality of employees hired to participate in patient care.

- Establish and maintain employee files. Place copies or documentation of references, credentials, licenses, continuing education, in-service training, etc. in their files. This reinforces the qualifications of your employees should this ever be in question.

- Health care personnel and professional employees, including physicians not covered under the medical practice’s professional liability insurance policy, should annually present evidence of adequate insurance.

- Experienced health care workers still need to be familiar with your office policies. Outline new employees’ responsibilities in a written job description.

- Require new employees to demonstrate proficiency in the tasks they are assigned. Prepare a skills inventory list for new staff detailing their required duties. Consider a probationary period and document the new employee’s successful completion of the skills list.
Office policies and procedures

Written policies and procedures in the form of a manual should be considered as a guide for staff.

• To facilitate orientation and to serve as a resource for all staff members, create and implement a policy and procedure manual that includes, but is not limited to, the following:

  1. HIPAA policies and procedures
  2. Scheduling policies
  3. On-call coverage for the physician(s)
  4. Medical emergency action plan
  5. Safety precautions
  6. Medication refill policies
  7. Telephone guidelines
  8. Problems requiring immediate notification of the physician
  9. Policies on the release of medical records
 10. What to do when legal correspondence is received
 11. Policies on tracking and filing of incoming laboratory, x-ray, and test results and/or reports
 12. Who may respond to patients’ complaints
 13. Billing and collection policies

• When policies and procedures are in place, they should be dated. When any revisions are made, the date should be changed and reflected as such (i.e., “Revised 01/01/05”).

• While the physicians maintain their individual practice parameters and protocols, items that involve patient-staff communication, infection control, patient and employee safety, release of information, etc. lend themselves to practice-wide standardization.

• All personnel using the policies and procedures should sign and date their acknowledgement and understanding of the policies. Where protocols are at the physician’s direction (e.g., medication, treatment, etc.) the physician should co-sign the policy and procedure indicating it was written to his/her standards.
Staff performance review and education

Each staff member should undergo periodic performance reviews by the physician or appointed reviewer such as the practice manager. This should be done to identify and discuss professional strengths and weaknesses, and goals for professional improvement.

- An annual review method based on, but not limited to, the following appraisal considerations can assist in distinguishing problem areas:
  1. compliance with office policies and protocols;
  2. competence in performance of assigned tasks; and
  3. compliance with medical record documentation guidelines.

Physicians and staff should regularly receive training and education in risk management and loss prevention.

- Programs to consider should cover review of federal and state regulations (such as HIPAA, OSHA, Safe Medical Devices Act, etc.), risk exposure identification and analysis, as well as patient communications, handling of patient complaints, medical record documentation and other pertinent topics.

- Education can be gained through in-service presentations or outside seminars.

CPR certification for office staff is beneficial in the event of a medical emergency

- Consider sending the staff to a CPR certification class or schedule a class in the practice.

Continuing education for physician(s) and staff should be encouraged. Monitor licensed staff with requirements for continuing education and maintain copies of certificates of completion in their personnel files to assure compliance.

- Provide staff with the opportunity to attend courses and seminars related to their job responsibilities.

- Ask professionals from your local hospital or health care organization to present in-services to your staff on current topics. These topics could include current or upcoming regulations in health care, a mini-lecture on medical conditions frequently seen in your office, infection control, informed consent, medical records, etc.

- Document any type of training that your staff receives. This could be a certificate of completion or a list of staff attending an in-service. Be specific about the qualifications of the speaker and the topic presented.

- Regular meetings give employees knowledge of expected behavior when dealing with patients, routine medical situations, administrative tasks, office safety and emergencies.

- Staff meetings should include the physician(s) so that no confusion about performance expectations occurs.
Risk management and quality improvement program

*Develop and implement a written risk management program for your practice to identify potential areas of exposure and reinforce the importance of risk management to the staff.*

• The risk management program should include a method to identify incidents and adverse occurrences arising out of the office practice setting. This will allow for documentation and tracking of events that occur for determination of the cause and any changes that may be required in office policy or practice to prevent recurrence.

• The program should have a system to routinely assess the quality of services provided by reviewing past and current medical records.

• An individual should be designated as risk manager/quality assurance manager and a risk management and safety committee should be formed in larger practices. In smaller practices, the staff meeting could double as the risk management/safety committee to discuss pertinent issues.

*Verify that staff members know the limitations of their knowledge, training and responsibility regarding patient care and advice.*

• Discuss with all staff the importance of not relaying any information that could be construed as medical advice to a patient or family member. Staff members who are registered, licensed, or certified should be familiar with their respective credentialing/licensing guidelines to assure that they do not overstep the bounds of their qualifications. Medical advice provided by either a non-physician, or a nurse outside the scope of the Texas Nurse Practice Act could be construed as practicing medicine without a license.

*Review office policies and procedures to be sure that you are in compliance with all required federal regulations.*

Federal regulations that affect physicians’ offices include:
  • HIPAA
  • OSHA (blood borne pathogens and chemical hazards communications)
  • Safe Medical Devices Act of 1990
  • Americans with Disabilities Act

Equipment maintenance and training files

*Records of equipment training and maintenance should be kept on file.*

• Medical equipment maintenance records that include the date the equipment was serviced and the servicer’s initials can provide proof that your equipment was regularly serviced according to contracts and agreements. Training and in-service on the use of equipment should also be documented.
II. PATIENT RELATIONS

Maintain office hours that are appropriate for your patient population (working parents, single parent families, or heavy industrial areas with shift workers).

• Know the needs of your patients. Periodically survey your patients for their preferences on issues such as office hours and weekend appointments. For example, you may wish to have an open schedule day for walk-in patients or Monday openings for patients with weekend illnesses. If your practice sees patients on an emergency basis, incorporate time for emergency visits into the daily schedule based on your previous experience.

• Schedule longer appointments for new patients. Encourage new patients to arrive early to complete forms. Tell patients in advance approximately how long their visit will take.

• Do not overbook appointments. This may lead to extended waiting periods and angry patients. Have an idea how much time particular visits and examinations will take in order to adequately schedule patients. To determine the length of an examination, take a sample time survey by recording the time a patient enters the examination room, the time the physician enters the room, and the time the patient checks out.

Remind the patient of their scheduled visit.

• Send a reminder card or call the patient the day prior to the scheduled appointment.

• If the patient cancels the appointment, reschedule while the patient is on the telephone. Document the cancelled visit and rescheduled date in the appointment book as well as the medical record. Do not erase or write over a cancelled or missed appointment in the daily appointment book. See Appendix 2 for Patient Cancellation/No-Show Documentation Stamp.

Establish a procedure for the staff to follow up on missed appointments.

• If a patient misses their appointment, document their non-compliance and any follow-up action taken. The physician should be made aware of the no-show and decide if the patient’s condition requires a follow-up call. Results of the follow-up call should always be documented in the patient’s record, even if to specify “no answer” or “telephone has been disconnected.”

• If the patient’s appointment has been scheduled by a referring physician’s office, notify that physician’s office of the cancelled or missed appointment so they may contact the patient and document the patient’s non-compliance in their record.

Have a pleasant, safe reception area with sufficient seating for patients and visitors.

• Create a positive image with a neat reception area. The appearance of the physician’s office practice may reflect directly on the patient’s impression of their physician’s attitude toward their care. An unkempt appearance may give the impression that the patient may receive less than standard care. A pretentious office may be a disadvantage as well.
• Continually assess your reception area, especially at peak appointment hours for seating capacity and comfort. Keep in mind that many patients are accompanied by family members and companions. Provide adequate seating even during the busiest hours.

• Review literature in your reception area to make sure it is current and does not contain articles detrimental to the practice such as “How to sue your physician.”

**Always notify the patient when the physician is running behind schedule and offer the patient the opportunity to wait for the physician or to reschedule.**

• Keep the staff informed of the physician’s whereabouts when he/she is out of the office and provide an expected time of arrival back at the office. Provide the staff with telephone and/or pager numbers where the physician can be reached. The physician should give the staff an estimated time of return, and keep them informed if emergency surgery, a delivery, or other unexpected event may delay their return. This will allow staff to reschedule the patient visits and avoid frustrating patients with long delays.

• The receptionist should advise patients in advance of extended waiting periods and give the patient a realistic waiting time. After reviewing the reason for the patient visit, offer the patient the opportunity to wait or reschedule. Patients to be seen for a major postoperative evaluation and suture or cast removal may need to wait. However, those scheduled for annual exams may be rescheduled, if desired.

• Evaluate how often patients wait longer than 15 minutes beyond the scheduled appointment time. Recording the exact time the patient checks in with the receptionist on the patient encounter form/superbill and the exact time the patient is called to the examination area will yield valuable information regarding how long patients are required to wait in the reception area.

• Make use of the waiting time by asking patients who have not been seen within the past 6-12 months to update information on their patient information/registration and history form.

**Teach staff how to handle patient questions or concerns about medical care and financial questions.**

• Patients’ questions and concerns about medical care should be referred to the physician or nurse for consultation. Patient and/or family statements indicating a misunderstanding of instructions should also be directed to the physician or nurse for clarification.

• Patients’ dissatisfaction or anger concerning medical services or financial matters should be referred to the physician and/or office manager for prompt resolution.

**Survey patients periodically for constructive feedback on improving the practice.**

• Patients are a valuable source of information and can provide constructive criticism that may assist a practice in maintaining and improving the quality of care provided. Written surveys can be sent in the mail with a monthly statement and a postage paid envelope or given to the patient at their visit. See Appendix 3 for sample Patient Survey Form.
Patient surveys that reflect discontent with delays in obtaining appointments or lengthy (non-emergency) delays in the reception area can be used to reassess the number of patients scheduled per hour/day. Physicians with busy practices should assess their workload to determine if they are able to meet the patient’s needs and maintain their good will.

*When dismissing a patient from medical care, it is advisable to do so in writing.*

- If the physician decides to terminate a physician-patient relationship, dismissal should be handled in an appropriate manner. Written notification by certified and first class mail is recommended. The return receipt and a copy of the letter should be placed in the medical record. A sample Letter of Withdrawal from Patient Care is included in Appendix 4. If the patient chooses to end their relationship with the physician, send them a letter confirming their decision. See Appendix 6 for a sample letter.

- If termination of the physician-patient relationship is being considered due to non-payment of fees, the need for continuity of care should be evaluated by the physician. It is strongly recommended that termination for this reason be used only as a last resort. See Appendix 5 for sample letters.
III. TELEPHONE AND COMMUNICATION PROTOCOLS

*Analyze your telephone system to make sure there are sufficient incoming lines for access to your office.*

Your telephone company can perform “busy” studies and “peak load time” studies for your practice to determine the need for additional telephone lines.

*Receptionists/operators should be professional and courteous when on the telephone.*

- Create written guidelines on how the staff should answer telephone calls and how to handle difficult patients. Calls should be answered as quickly as possible. The receptionist should identify the practice by name, give his or her name and ask, “How may I help you?” when answering calls.

- The receptionist/operator should ask for permission to put a call on hold, and wait to hear the caller’s response before placing the call on hold. It may be an emergency situation that should not be delayed.

- Keep calls on hold to a maximum of two minutes. Many telephone systems have automatic ring back features that require the staff to address the holding call again at certain pre-set intervals. If your system does not have an automatic ring back feature, staff should check on holding lines frequently. If more time is needed to assist the caller, encourage the staff to take a message with the caller’s permission, and get back to the caller promptly.

- Treat irate callers with unfailing politeness. Complaints about the practice should be reported directly to the office manager and physician(s) for prompt response.

- Periodically monitor the staff’s telephone performance to ensure that they are representing the practice in the manner you wish. Try calling in on a patient line to observe how the call is answered or have another individual whose voice is unknown to the staff call the practice for general information. Ask them to report back to you how their call was handled.

- Large rural practices may wish to consider a toll-free telephone number for out-of-town patients to use.

- Have a dedicated pharmacy telephone line to reduce the volume of calls placed on patient lines.

*Protect patient confidentiality.*

- Do not allow telephone conversations to be overheard in the reception area.

- Verify that you have the correct caller on the line. When returning to a call on hold, begin the conversation by using the caller’s name and listen for their reply before discussing medical information.
• Do not release medical information over the telephone to a party other than the patient unless you have the patient’s written authorization and you are certain of the caller’s identity. For instance, if a new insurance company employee who is unknown to you requests information for reimbursement purposes, ask for their telephone number and call them back through the company’s main switchboard to verify their identity.

**Develop a protocol outlining which telephone calls should be transferred and handled by the physician, nurses, staff, etc.**

• Non-medical personnel should never give medical advice. Train office staff to identify which telephone calls should be immediately transferred to the physician, the nurse, the emergency room, etc.

• Busy offices can handle medical questions through a telephone screening and advice protocol. See Appendix 7 for a sample Telephone Decision Grid to help staff direct/manage patient phone calls. Prepare specific guidelines for the nursing staff to use when answering patients’ medical questions without overstepping nursing boundaries. Post the grid by all office phones for reference.

**Require documentation of all patient telephone contacts in the medical record.**

• Documentation of telephone conversations should include:
  1. Date and time of call
  2. Caller’s name and relationship to the patient
  3. Patient problem/complaint
  4. Advice given/action taken/physician’s directed order
  5. Caller’s response
  6. Staff’s signature or initials

• Document after-hours calls and any instructions given to the patient in the medical record. This information can serve you and subsequent caregivers in providing the patient’s medical care. Methods may include answering service logs, dictated notes on the office dictation system or answering machine, telephone message pads, or direct entry via electronic record systems. See Appendix 12 for a sample Message Pad.

• Phone call documentation should indicate if the staff was unable to contact the patient with an entry such as “no answer” or “telephone disconnected”.

**Schedule call back hours for non-emergency telephone calls to reduce interruptions. Provide patients with a time range for a return call.**

• Return non-emergency patient calls within 4 hours if possible, i.e., before lunch and after patient appointment hours at the end of the day. Avoid waiting until the following day to return calls, if at all possible.

• Give the patient a specific time period to expect a return call from the physician or nurse. This demonstrates respect for the patient’s time.
Policies and procedures for the use of electronic communication should be developed by the practice.

• Use e-mail communication only with established patients.

• Educate patients who elect to use email about your email policies. Ask them to sign an email consent form. Your consent form should include when the use of email is appropriate (i.e. not appropriate for use in an emergency). See Appendix 15 for Sample Email Policy and Consent.

• Automatic reply to all incoming messages is helpful. Sample wording may include, “Your message has been received by [practice name]. We will attempt to process your request within one business day. If you need immediate assistance, please call [phone number].

• All email regarding patient care should be filed in the patient’s medical record.

• One staff member and one back-up staff member should be responsible for checking and routing all incoming email in a timely fashion.

• Double check the “send to” field before sending the email. Include a banner that states, “This is a confidential medical communication” at the beginning of the message.

• Review HIPAA Security Standards to ensure that your electronic communications are secure and protected.

Instruct office staff on policies and procedures regarding telephone medication prescriptions and refills.

• Physicians should develop procedures for the staff to follow when patients request changes in their medication or prescription refills.

• Give the patient’s medical record to the physician with the request for the prescription refill, so that the medication history can be reviewed before authorizing the refill. Reviewing the record at the time of the refill request can help identify compliance problems, drug-drug reactions and potential abuse.

• Medications prescribed or refilled by telephone should be documented in the medical record. Documentation should include the date, drug name, route, duration, amount and number of refills, and the initials of the person approving the refill. See Appendix 8 for a sample Medication Flow Sheet that can be used to document not only telephone prescriptions and refills, but also office prescriptions or over-the-counter medications.

• For all standard prescriptions refilled by office staff, the physician should co-sign the entry in the medical record. If this is not possible, develop a written policy outlining the specific circumstances in which staff can authorize refills, and when the patient will need to be seen again before a refill can be approved. This may alleviate any questions regarding authorization to prescribe medications should an adverse event occur.

Record telephone conversations with consultants about the patient in the medical record.
• In many cases, urgent findings must be relayed to the referring physician by telephone before a dictated report is submitted. Make notes of these conversations in the patient’s record, especially when a change in orders or care occurs.

Document telephone calls in which test results are conveyed to the patient in the medical record.

• Following review by the physician, lab results may be reported to the patient by office staff.
• Documentation on the test report or lab slip will suffice. The date of the call and initials of the staff member advising the patient of the results should be included as well as any recommendations. Note if the patient was told to return to the office or seek other medical attention and any other pertinent information. See Appendix 9 for a sample Diagnostic Report Review Label.

Practices should have ways for patients to contact a physician after hours.

• Use of an answering service or machine is helpful in advising the caller on how to reach a physician when the office is closed. If you use an after-hours answering service, monitor the service periodically to confirm that they are representing your practice in a positive manner. If using an answering machine, it is important to include relevant information on the message such as office hours, the time to call back to speak with the staff, and emergency number(s) to contact the physician and/or 911, hospitals, etc.

Office staff should have a list of emergency telephone numbers readily available, including poison control, the police department, etc., and should be prepared for office emergency situations.

• The staff should be ready for any emergency situation in the office. Appropriate actions should be assigned to specific employees, whose duties may include calling 911, CPR initiation, contacting the physician, etc.
IV. CONFIDENTIALITY

*Protect your practice by remembering that patients’ personal data, medical notes, and billing information are confidential.*

• When using sign-in sheets, take measures to protect patient privacy.

• The entire staff must be instructed not to communicate confidential information to others without the patient’s signed authorization. Ask staff to sign the practice’s Confidentiality Agreement. See Appendix 1 for sample Confidentiality Agreement.

• Do not discuss a patient’s condition with the office staff, family members or friends unless absolutely necessary. Avoid these discussions in hallways, elevators and public areas, even when within the confines of your office.

• Do not make derogatory statements about patients or staff as they can be overheard and then repeated. Any discussions should take place in a private area.

• Conversations regarding financial issues or payment schedules are confidential and should take place in a private area, such as an empty office or exam room.

*Medical records release responsibilities should be centralized in one area with one individual to oversee and manage record releases.*

• This individual should be well oriented to both the Texas Rules and Regulations and HIPAA Privacy Rule governing confidentiality and release of record issues. See Appendix 10 for a sample Authorization to Release Health Information.

• Consider physician review of the request for medical records and the records to be released. Make certain valid patient authorization is secured before release of records.

*Faxing patient information to other providers has become common. Precautions should be taken to prevent unintentional release of confidential information to the wrong party.*

• Locate your fax machine in a secure place, away from patient areas.

• Faxed information should have an attached cover sheet. See Appendix 11 for a sample Fax Cover Letter that indicates that the information is confidential, and provides instructions on how to return the information, should the wrong party receive it.
V. EDUCATION AND CONSENT

Adequately inform patients about the services they can expect from you, and what you expect from them.

You may wish to develop a patient brochure that includes the following:

1. Services they can expect, including medication refills
2. Fees for those services
3. Billing procedures
4. Procedures for resolution of any patient complaints
5. Practice policy regarding no-shows

• Practices with websites are advised to include a statement describing the site as informational, not for the purpose of offering medical advice or treatment. Websites should be kept current and include the date last updated. Statements implying guarantees or warranties should be avoided.

• Have information about your practice, including a posted copy of your Privacy Notice as required by HIPAA, available in the reception area and on your website, if applicable. If appropriate to your practice, use bilingual information and signs.

• Post signs in the reception area with the practice’s payment policy and office hours. Post bilingual signs as appropriate

Maintain up-to-date general health and preventative medical literature for patients.

• Current patient education materials are produced by many specialty societies to assist in general and preventative health education (vaccination schedules, cancer prevention material and other information depending on the physician’s specialty).

• Providing brochures, videos and informational materials for patient review may stimulate questions and encourage patients to disclose more details about their medical history or concerns. Document patient education in the medical record, whether oral, printed, or audio-visual.

• Many forms, brochures, and educational materials have been translated into Spanish and other languages, and are available through medical specialty societies and other organizations.

Physicians and staff should avoid implying any guarantees or warranties regarding outcomes of procedures or treatments.

• Avoid implied promises such as “I’m going to make you beautiful,” either oral or written.

• Staff should refrain from comments like “the doctor does this all the time and has never had problems.”

Conduct informed consent discussions with the patients to educate them about the procedure or treatment and allow patients to make informed decisions about their care.

• The physician, not a delegated representative, is responsible for obtaining informed consent and should discuss the following with the patient:
  1. the risks and benefits of a proposed treatment or procedure;
  2. alternatives to a proposed treatment or procedure;
  3. the risks and benefits of the alternative treatment or procedure; and
  4. the risks and benefits of refusing treatment.

• Informed consent should be obtained when elective procedures are agreed to by the patient. The office environment is conducive to the question and answer period necessary to provide informed consent. The conversation, associated risks, benefits and alternatives should be documented in the patient’s record, along with a reference to the conversation. This may afford the physician increased defensibility should an adverse event occur.

• If a family member or friend accompanies the patient, document that person’s presence and name.

• Provide the informed consent disclosure information in the primary language of the non-English speaking patient, if possible. Contact the Texas Medical Disclosure Panel, Texas Department of State Health Services, for consent forms in Spanish.

• When performing office procedures not requiring written informed consent, or prescribing medications with known risks, it is advisable to document patient education and consent to treatment. The physician may document this discussion in the progress note, or your office may wish to develop a basic consent form.
VI. DOCUMENTATION

All forms completed by the patient, including the patient acknowledgement of HIPAA’s Notice of Privacy Practices and initial history forms, should be reviewed for completeness. Important information, such as allergies, should be noted.

• New patient forms should be checked by staff to be sure all questions have been answered. Particular attention should be paid to drug allergies and adverse reactions. Medical record forms left blank or unanswered by the patient, physician, or staff may be open to conjecture by others reviewing records.

• Patient drug allergy information that is boldly noted and visible in the medical record and/or on the outside of the folder can prevent this important information from being overlooked when prescribing medications and/or treatments. Document “NKA”, “NONE,” or “NKDA” when the patient does not have any allergies.

Practices can benefit from having easily located, organized medical records.

• Medical practices are encouraged to maintain a medical records system that uses numerical identification. Common last names can pose record identification problems if alphabetical systems are used. Patient account numbers assigned in the computer system can provide the alphabetical cross-reference for locating medical records. If an alphabetical system must be used, be sure to document “NAME ALERT” on the medical records of patients with similar names.

• Label tabs within the record for ease in locating chart notes, drug allergy information, diagnostic testing, lab results, consultation reports, and financial information. At a minimum keep financial information and patient care information divided.

• To avoid losing medical information and to better facilitate patient care, each page of the medical record should be secured in the record, and should include the patient’s name, social security number, date of birth, or in-office record number.

The use of dictation is encouraged.

• When dictation is used, the following components should be included to make sure the entry is clear:
  1. date of dictation
  2. date of transcription
  3. transcriptionist’s initials

• Dictation entries should be proofread by the physician and initialed or signed as an accurate representation of the physician-patient encounter.

• While the use of wording such as “Dictated But Not Read” is an honest illustration of a physician’s busy schedule, it does not necessarily reflect the thoroughness you wish to exhibit in your records.
Physicians and staff members documenting in the medical record should initial or sign their notes in the event their assistance is needed to verify an entry in the record.

- A signature validates the entry and is further authentication of the physician or staff encounter with the patient. Unsigned entries may pose problems in defending professional liability claims.

- Practices may wish to keep a signature log of all staff names, their full signatures, and initials in order to identify record entries. Many liability allegations arise years after an incident, and staff initials may no longer be identifiable. If no one can determine who made an entry, an important witness to the physician’s defense may be lost.

Medical records, whether paper or electronic, should be thorough and well organized to protect the physician’s interest and provide a defense against any liability allegations. According to the TSBME rules, guidelines for medical records are:

165.1. Medical Records.
(a) Contents of Medical Record. Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an “adequate medical record” should meet the following standards:

(1) The documentation of each patient encounter should include:
   a) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   b) an assessment, clinical impression, or diagnosis;
   c) plan for care (including discharge plan if appropriate); and
   d) the date and legible identity of the observer.

(2) Past and present diagnoses should be accessible to the treating and/or consulting physician.

(3) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.

(4) The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance should be documented.

(5) Relevant risk factors should be identified.

(6) The written plan for care should include when appropriate:
   a) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
   b) any referrals and consultations;
   c) patient/family education; and,
   d) specific instructions for follow up.

(7) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
(8) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.

(9) Records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.

(10) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient's status. Paragraphs (1)-(10) of this subsection may be modified to account for these variable circumstances in providing medical care.

- Documentation of the refusal for medical treatment or surgical procedures is also recommended. If the refusal of care may potentially affect the quality or length of the patient’s life, consider asking the patient to sign an “informed refusal.” See Appendix 13 for sample Informed Refusal

- Patient non-compliance should be noted in the record. This may demonstrate contributory negligence by the patient or establish that the physician was not negligent if failure to follow the physician’s recommendations results in an injury.

*Medical records should be corrected to allow the mistake to be viewed and the correct information to be added without doubt as to what occurred.*

- “White-out” correction fluid should not be used to correct errors in medical record documentation.

- Corrections should consist of one line through the error with the date and initials of the individual making the correction. Masking an entry tends to lead to questions as to why an entry was changed.
Electronic records

Electronic records should be assessed for the following:
1. Each entry is authenticated with physician or staff name or initials to indicate ownership of entry.
2. Patient encounter notes are locked in a timely fashion (24 to 48 hours is recommended), and include author’s electronic signature and date.
3. Addendums to encounter notes are identified and include the reason for late entry, name or initials of author, and the date.
4. To prepare for record requests, print a sample record to ensure it is complete.
5. Daily backup is done and the backup file is stored at another location.

Implement procedures for follow-up on diagnostic testing and results. Documentation of actions is recommended.

• For patients referred to consultants or any outside source for examinations, lab or diagnostic testing, consider a tracking system to ensure the patient is seen and results are received. Consider maintaining a “pending” folder or log to determine if results have been received in your office. See Appendix 14 for a sample Tracking Log. Additionally, you may wish to schedule the consultation and test appointments for the patient, requesting your office be advised if the patient does not keep the appointment. Document the patient’s non-compliance in your record.

• Upon review, all test results should be initialed and dated by the physician prior to filing. It then becomes clear that all results were reviewed. As an alternative, physicians may choose to document their review and the date in the progress notes. When appropriate, documentation regarding actions on specific results should be noted in the patient’s record. When the patient is informed of results, an entry on the report will suffice. Record the date of the call and initial the entry. See Appendix 9 for a sample Diagnostic Report Review Stamp.

For continuity of care within your practice, physicians should document in the medical record as well as on the patient encounter (superbill) form when they wish to see the patient back in the office for a follow-up visit.

• This enables the office staff to schedule the return visit, thereby providing a system that may prevent allegations of failure to follow up.

Have a documentation system that records follow-up of cancellations and no-shows. This system should assist the physician in identifying those patients whose conditions require a revisit.

• Particular attention should be directed toward postoperative visits and checkups following office procedures. Documenting calls or letters to the patient demonstrates your efforts to contact the patient should a problem subsequently occur. See Appendix 2 for a sample Patient Cancellation/No-show of Scheduled Appointment documentation prompter.

Establish a protocol to handle the receipt of legal correspondence.
• Immediately give the physician all legal correspondence such as subpoena and affidavit, notice of claim, or suit papers and plaintiff’s original petition and citation, and any letters from attorneys.

• Secure any and all information that relates to the case, including all medical records, x-rays, or other patient-related information. Keep this information together.

• Keep all legal correspondence in a separate file. Avoid incorporating any legal information or information not directly related to the care/treatment of the patient into the medical record.
VII. PATIENT CARE

_Respect your patients’ privacy and safety when designing your examination rooms._

- Arrange exam room tables to ensure patients are not viewed from the hallway by others.
- If possible, provide screened dressing areas in the exam room for patients. Knock before entering the room to warn patients of your arrival.
- Furnish exam rooms with non-skid step stools to assist patient access to the exam table.
- Assign a staff member the duty of inspecting exam rooms periodically for patient safety.

_The patient’s medication history should be documented in the record to avoid the hazard of polypharmacy and drug-drug interactions._

- Encourage patients to bring their current medications with them for identification and documentation to avoid having to list “unidentified” medications in the patient’s record. When patients schedule an appointment, ask them to bring a complete list of current medications, herbal products, vitamins, etc.

_Patients who may be subject to polypharmacy due to chronic illness or conditions and/or seen by multiple physicians should have their medication histories reviewed at each visit._

- This will prevent drug-drug incompatibilities and drug-induced illness like depression, severe hypotension and other serious illnesses as a result of polypharmacy.
- Consider using a medication flow sheet to monitor the patient’s medications, prescriptions, and refills. See Appendix 8 for a sample Medication Flow Sheet.

_Patients presenting for monthly or weekly injections should have their vital signs checked periodically._

- Occasionally medication regimens may mask other, more serious illnesses. Consistent patient complaints should be investigated, and more serious possibilities ruled out. Document the vital signs in the record.

_Consider implementing a procedure to follow up with patients the day after a diagnostic study (i.e., cardiac stress test, barium study, or IVP, etc.)._

- In addition to enhancing patient relations, this follow up can ascertain the response to a procedure and determine if there were any adverse outcomes or side effects. Document the conversation with the patient in the medical record and report any abnormal responses (fever, elevated pain) to the physician.

_Physicians can avoid allegations of inappropriate behavior if a staff member is present during exams and office procedures._
• A staff member’s presence will not hinder the patient-physician relationship but provide a sense of comfort to both the patient and the physician when exams or procedures are performed.

_Outpatient care and surgery in the medical office should include appropriate preoperative evaluation and postoperative monitoring to ensure patient stability before discharge._

• Preoperative patients should provide a complete medical history, including past and present medications and any over-the-counter medications. When forms are used, blanks should either be completed or marked “not-applicable” when indicated.

• Pre- and intraoperative blood pressure and pulse oximetry information should be documented in the patient’s record. Failure to do so may give the impression that those patients were not monitored.

• Pre- and intraoperative medications should be documented with the time, route, dosage and signature of personnel administering.

• Postoperative monitoring and evaluation for an adequate time period is suggested. Documentation in the medical record of the length of the patient’s recovery time and condition at the time of discharge is recommended.

• Postoperative notes should include documentation that vital signs were checked every 15 minutes for one hour. Discharge vitals should include temperature. A summary should be entered into the medical record regarding drainage, vital signs, skin color, mental orientation, pain status, ability to void and any other pertinent discharge criteria such as method of discharge (ambulatory, wheelchair).

• Portable oxygen tanks should be in each recovery area.

• Pre-printed and appropriately marked discharge instructions should routinely be given to the patient or their parents/guardians with a signature acknowledging receipt and understanding. Maintain a copy in the medical record. Any discharge medications or prescriptions should be also noted along with the scheduled follow-up appointment.

• All patients should be called the day after surgery with a checklist of questions. Responses should be recorded, filed in the medical record, and reviewed by the physician.

_Have quality assurance guidelines for x-ray and EKG readings._

• Over-reads are recommended by a second physician or preferably by a radiologist/cardiologist on a regular basis.

• Maintain an x-ray tracking procedure to ensure x-rays checked out of the office are returned.
VIII. Safety

*Consider accessibility and safety when designing your practice.*

• Be aware of potential risks that could cause injury to patients and visitors such as tripping hazards, defective furnishings, and electrical wiring.

• Comply with the Americans with Disabilities Act when designing or remodeling the office.

*Maintain a building and parking lot that is adequately lighted and free from potential hazards that could cause injuries to your patients, the public or the staff.*

• Routinely tour the office, building and grounds for exposures. Secure any hazardous areas from future exposure by posting warning signs. Notify proper sources to assure that any problem is corrected as soon as possible. Your practice may incur liability for failing to repair or report safety hazards.

• If leasing space in a building, advise the building management of the problem immediately and follow the situation through to completion.

*Be prepared for an emergency evacuation in the event of a fire or other disaster.*

• Make sure exits are clearly marked in the reception areas and throughout the office.

• Train the office staff in emergency evacuation procedures so they can properly assist the patients and the public. Delegate assignments based on office responsibilities.

*Require proof of insurance from contractors and vendors performing services in your office setting.*

• Before allowing work to begin, request the service provider present a certificate of insurance which details the provider’s workers’ compensation, general liability and products liability insurance coverage. Maintain a copy in the same location as the contractor’s agreement.

*Avoid tempting unattended persons. Keep prescription pads, syringes, drugs and sample medications out of sight, particularly in the examination rooms.*

• Preferably, prescription pads should be carried by the physician in a pocket.

• Assess the office for items in plain sight that may best be stored, locked or removed from exposure to theft.

*Medications, controlled drugs and sample drugs should be stored in a safe location and unavailable to patients and other outside individuals.*

• Controlled drugs should be kept secure and monitored per Texas Administrative Code guidelines.
• Separate medications with similar sounding names to prevent dispensing the wrong drug.

• Check samples monthly for expiration dates. Avoid keeping drugs you do not prescribe or which are inappropriate for your practice.

• Dispensing samples is no different than pharmacy dispensing. Maintain accurate documentation of dose, route and directions for the drug, along with a discussion of side effects and potential adverse interactions.

_Establish procedures for office emergency situations. Have the necessary emergency equipment and protocols in place for your staff to initiate a quick response._

• Emergency equipment should be maintained to facilitate transportation of equipment to the scene of the emergency (e.g., rolling cart with drawers, tackle box, etc.).

• Electrical equipment, such as vacuum suction, should be regularly maintained and operated to ensure it functions properly.

• Minimum recommended medical emergency kit items should include an Ambu-bag, oxygen, and oral airways in a variety of sizes. Resuscitative drugs, IV fluids, and a defibrillator may be obtained at physician discretion and based on the practice specialty.

• Emergency battery-operated lighting should be kept on premises to provide a source of light in the event of power failures, especially if the physician is in the process of doing a procedure. If your building or office does not have an emergency generator, consider placing chargeable flashlights in patient care or treatment areas.

• For evacuation in case of fire or other disaster, consider placing a copy of a diagram of the building with the fire evacuation route in all patient care areas and on the back of each exam room door. Exit signs should be used to identify an evacuation route.

_The practice should be in compliance with federal and state regulations concerning medical equipment._

• Policies and procedures should be implemented to ensure your facility’s compliance with the Safe Medical Devices Act of 1990. Contact the Food and Drug Administration, Office of Training and Assistance for information.

• Product safety and recall information should be maintained. Document actions taken by the office and patient notification per instructions from the manufacturer or the FDA.

_Medical practices should be in compliance with OSHA on chemical hazard standards._

• Develop a program and documentation system relating to chemical hazards in the practice. Medical offices are required to maintain an OSHA manual and current Material Safety Data Sheets (MSDS) furnished by the supplier for all chemicals. For assistance in designing a program, contact your local OSHA office or access the website.
Medical equipment should be checked at least annually or in accordance with manufacturer’s recommendations.

• Equipment should be tagged with the date of service and initialed by the person servicing the equipment. Credentials should be maintained on the individual or firm performing the maintenance.

Gas cylinders should always be stabilized, either in wire cages or secured to a stable surface.

• Stabilization avoids the risk of the cylinders falling and exploding. The room should also be identified as housing gas cylinders to warn individuals of the potential dangers inside the room. A simple sign such as “Medical Gases” will suffice.
IX. INFECTION CONTROL

*Front office and billing staff should be educated about infection control strategies.*

- Ensure that the reception area is kept clean.

- Instruct your cleaning service on your requirements and proper maintenance of this high traffic area.

- If furnishing toys for pediatric patients, consider their potential as a source of cross-contamination and can they be adequately cleaned and disinfected?

*To avoid the spread of illness among patients in the reception area, provide a separate reception area when possible for contagious patients.*

- An unoccupied exam room or patient education room may be used to separate contagious patients from others in the reception area.

*If possible, provide a separate restroom for staff use.*

- Separate restroom facilities can reduce staff exposure and the spread of contagious diseases. Encourage staff to use their designated restroom facility.

*Review your policies and procedures for infection control with clinical staff.*

- Review the importance of hand washing before patient contact. Staff should use antimicrobial/antibacterial soap for at least 15 seconds.

- Review the principles of disinfection and sterilization with the staff person responsible for disinfection and sterilization of instruments.

- Be sure that instruments to be sterilized are thoroughly cleaned and packaged prior to sterilization. If the instrument is dirty or is improperly packaged, contamination could occur during a procedure or treatment.

- Pans containing instruments in a disinfectant solution should be dated to monitor the age of the solution. It is recommended that the disinfection solution be changed at least monthly. In the interim, be sure that the instruments are completely covered with the solution so that debris is not allowed to dry on the instrument. Add more solution as needed since these solutions can evaporate.

- Date sterilized packages and place them on a shelf or in a drawer using the last-in last-out method.
The practice should be in compliance with federal and state regulations regarding infection control, exposure to bloodborne pathogens and universal precautions. See the Risk Management Strategies above in addition to strategies listed below.

• OSHA regulations should be implemented in your office. OSHA may perform random compliance audits, and the fines for willful negligence are steep.

• The following areas should be addressed within your OSHA Manual and Exposure Control Plan, covering exposure to bloodborne pathogens and universal precautions:
  - exposure determination
  - engineering/work practice controls
  - personal protective equipment
  - housekeeping
  - labeling and bloodborne communication
  - HBV vaccination
  - post-exposure procedure
  - training
  - record keeping
  - waste disposal, sharps disposal
  - waste documentation

• For detailed information on regulations, compliance, and audits or consultants, contact OSHA at www.osha.org.

Implement Texas Department of State Health Services guidelines for reportable communicable and sexually transmitted diseases.

• Review the Texas Department of State Health Services Rules and Regulations for the Control of Communicable and Sexually Transmitted Disease and Reporting of Occupational Diseases. Refer to www.dshs.state.tx.us

Reduce your exposure to cross-contamination in the patient care/examination area.

• Food requiring refrigeration should be kept in a separate refrigerator from the one used to store medications, specimens, etc.

• Food and beverages should not be consumed in patient care areas. When mixing medications or other patient care materials, aseptic technique should be maintained.

• Between patients, disinfect counters or other surfaces in patient care areas that could be sources of contamination.
X. APPENDICES— PRACTICE MANAGEMENT TOOLS

1. Employee confidentiality statement
2. Patient cancellation / no-show documentation stamp and letter
3. Patient survey form
4. Letter of termination of physician/patient relationship
5. Letters of non-payment and termination for non-payment
6. Letter of confirmation patient terminated relationship
7. Telephone decision grid
8. Sample medication flow sheet
9. Diagnostic report review stamp
10. Authorization to release health information
11. Fax cover letter
12. Message pad
13. Informed refusal
14. Result tracking log
15. Email policy and consent

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Appendix 1.
Employee confidentiality statement

SAMPLE

Statement of confidentiality

Information concerning patients is strictly confidential. At no time should patient information be discussed during casual conversation or with any unauthorized persons. Unauthorized release of confidential information is very serious and may involve the offender and the medical office in litigation. In general, authorized persons to receive information on patients include only a) those who have the written consent of the patient, b) physicians and personnel involved in the diagnosis, evaluation, or treatment of the patient, or c) health plan personnel involved in QI or UM activities.

Examples of breach of confidentiality:
- discussing a patient’s condition or treatment when it is not necessary for their care;
- naming a patient and their condition in a public setting;
- speaking of a patient within hearing of other patients or other unauthorized persons;
- reading a patient’s chart when not related to their care; and
- asking co-workers about the condition or treatment of a patient or employee;
- reading correspondence or information related to a patient or employee and/or discussing that information with others.

Examples of poor sensitivity to patients that could be construed as a breach of confidentiality
- asking loudly in the waiting room about a patient’s condition, treatment, lab work, test results, etc.;
- making light of a patient’s condition or personal characteristics; and
- discussing the personal matters of another employee within hearing of patients or other employees.

I, the undersigned, do hereby agree not to divulge, discuss, employ, or use any confidential information obtained from my association with and/or period of employment in the medical office. This is a statement of my understanding of the importance of confidentiality in all areas of medical care, and that any violation on my part of patient confidentiality may be grounds for my termination.

_________________________________  __________________________
Employee signature                      Supervisor signature

_________________________________  __________________________
Date                                  Date
Appendix 2.
Patient cancellation /no-show documentation stamp and letter

Date: __________________________
Reason: _________________________
______________________________
Rescheduled: __________________
Initials: _______________________

The above may be developed into a self-inking stamp.
Patient cancellation/no-show documentation letter

SAMPLE

Your letterhead

Date

Certified receipt # ______________
Also sent regular mail.

[Patient address]

Dear [patient name]:

You did not return for your scheduled appointment on [date] and you have not contacted the office to reschedule your appointment. Our efforts to reach you by phone have been unsuccessful, and there has been no reply to our messages [indicate specific dates or number of attempts.]

As we discussed, it is important that your condition be monitored. Upon receipt of this letter, please contact the office to reschedule an appointment. If you decide to seek care from another physician, please notify me as soon as possible. Upon receipt of an authorization to release medical information, your record will be forwarded to your new physician.

Sincerely,

[physician name]

[Send letter via certified mail and first class mail and place a copy in the patient’s record. When the certified receipt is returned, put it in the record.]
Appendix 3.  
Patient survey form

SAMPLE

Your letterhead

We value our patients and invite your comments, suggestions, or complaints about the care we provide. By evaluating the strengths and weaknesses of our practice, you will assist us in providing better health care to our patients.

1. Was the staff friendly and courteous?  
   Yes  No

2. Are our office hours convenient?  
   Yes  No

3. Is it easy to make an appointment?  
   Yes  No

4. Do we see you on time for your appointments?  
   Yes  No

5. Do you feel that we spend enough time with you?  
   Yes  No

6. Were our explanations clear and were all of your questions answered to your satisfaction?  
   Yes  No

7. Does our staff return telephone calls in a timely fashion?  
   Yes  No

8. Do we meet your expectations?  
   Yes  No

9. Is there one specific area where we could improve?  
   Yes  No

_______________________________________________________________________

_______________________________________________________________________

Signature (optional)

_______________________________________________________________________

Thank you for your comments
Appendix 4.
Letter of termination of physician/patient relationship

SAMPLE

Your letterhead

Date                                      Certified receipt # ______________
                                               Also sent regular mail.

[Patient address]

Dear [patient name]:

Please be advised that I will no longer be able to treat you as a patient. The termination of our physician/patient relationship will be effective in 30 days from the date of this letter. Your medical condition requires continuing physician supervision, and it is important you select another physician as soon as possible.

Contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, a copy of your medical record will be sent to your new physician. A release form is enclosed.

Sincerely,

[physician name]

[Send letter via certified mail and first class mail and place a copy in the patient’s record. When the certified receipt is returned, put it in the record. You are not required to state a reason for termination, but may acknowledge failure to follow medical advice or keep appointments. It is inadvisable to state a reason such as incompatible personality.]
Appendix 5.
Letter of non-payment

SAMPLE

Your letterhead

Date

Certified receipt # ______________
Also sent regular mail.

[Patient address]

Dear [patient name]:

It has come to my attention that you have received several letters regarding your outstanding account. If there has been a problem or if you are unhappy with the care that you have received in this practice, please contact me to discuss the situation. You are important to us, and I hope we can resolve any issues you have.

My business manager is also available to discuss payment of your account or to implement payment arrangements if they are needed. Should we not hear from you within 30 days, I believe that it would be mutually beneficial to terminate the physician/patient relationship so that you may locate a new physician.

I hope that we will hear from you in the near future

Sincerely,

[physician name]

[Send letter via certified mail and first class mail and place a copy in the patient’s record. When the certified receipt is returned, put it in the record.]
Letter of termination for non-payment

SAMPLE

Your letterhead

Date

Certified receipt # ______________
Also sent regular mail.

[Patient address]

Dear [patient name]:

On [date], I sent you a letter requesting that you contact the business manager or me regarding any problems that may have occurred resulting in non-payment of your account. In the letter, I stated that it would be necessary to terminate our physician/patient relationship if we did not hear from you.

Since we have not heard from you, please be advised that I will no longer be able to treat you as a patient. The termination of our relationship will be effective in 30 days from the date of this letter.

A release form is enclosed for your written authorization. Please contact us with the name of your new physician so we may forward your records to his or her office. At that time, your account will be closed.

Sincerely,

[physician name]

[Send letter via certified mail and first class mail and place a copy in the patient’s record. When the certified receipt is returned, put it in the record.]
Appendix 6.
Letter of confirmation patient-terminated relationship

SAMPLE

Your letterhead

Date

Certified receipt # ______________

Also sent regular mail.

[Patient address]

Dear [patient name]:

This letter is sent to confirm your decision to discontinue care with me. Your medical condition requires physician supervision, and it is important you select another physician as soon as possible. I will be available to you until [30 days from date of letter].

Please contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, I will provide a copy of your medical record to your new physician. A release form is enclosed to expedite the process.

Sincerely,

[physician name]

[Send letter certified and regular mail and place a copy in the patient’s record. When the certified receipt is return, put it in the record.]
Appendix 7.
Telephone decision grid

### SAMPLE

Physician checks column on how calls are managed.

<table>
<thead>
<tr>
<th>Types of Calls</th>
<th>Refer to ER</th>
<th>Refer to MD stat</th>
<th>Refer to RN/LVN</th>
<th>MD will Call ASAP</th>
<th>Take Message/RL MD Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Symptoms</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Temp over 103°</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Severe pain</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Trauma</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Reaction to medication</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Ingestion — possible poisoning</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Chest Pain — unrelenting</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Disoriented/confused</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Heavy bleeding</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Wound separation</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Post part numbness/childbirth</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Loss of motor function/sensation</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Hospital calls</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Pake value</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Urgent</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Routine</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Pathological</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Radiology</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Staff</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Radiologist</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Life threatening</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Other</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>OR</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Elective</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Staff</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Anesthesiologist</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>L &amp; D</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Off duty</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Obstetrician</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Hospital Administration</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>President, Medical Staff</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Department Chief</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Committee Chairman</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Requests</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Physician requests information</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
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<tr>
<td>Condition</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
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<tr>
<td>Family requests information</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>on medical condition</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Physician requests test results</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Physician requests refills</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Physician requests medication change</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Physician requests copy of medical records</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Assurance company</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Attorney</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Other directives</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
</tr>
<tr>
<td>* Refills</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
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<tr>
<td>* Questions</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
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<td>Other</td>
<td>Notify MD</td>
<td>MD stat</td>
<td>RN/LVN</td>
<td>MD will Call ASAP</td>
<td>Take Message/RL MD Call</td>
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Appendix 8.
Medication flow sheet

SAMPLE

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medication Sheet</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td></td>
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<tr>
<td>Medical Record</td>
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<tr>
<td>Other Doctor</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem No.</th>
<th>Date Discovered</th>
<th>Problem</th>
<th>Remarks</th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Start Stop</th>
<th>Medication Dosage/Directions/Amount</th>
<th>Refills: Date/Amount/Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Appendix 9.
Diagnostic report review stamp

MD initials _______________ Date ______________

☐ Notify patient within normal limits
☐ Call patient to discuss
☐ Call patient and schedule return appointment

The above may be developed into a self-inking stamp.
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 # ________________________(optional)

I authorize the following individual or organization to disclose the above named individual’s health information:

__________________________________________________________  Address:____________________________

This information may be disclosed TO and used by the following individual or organization:

__________________________________________________________  Address:____________________________

For the purpose of:________________________________________________________

Please release the following: {Note: list not required by HIPAA}

1. __Entire Record

2. or:  ___Problem List  ___X-Ray/Imaging Reports-from (date)________ to (date)________

3. ___Progress Notes  ___X-Ray Films

4. ___History/Physical Exam  ___Laboratory Results-from (date)________ to (date)________

5. ___Medication List  ___EKG Reports

6. ___Immunization Record  ___Genetic Testing Information

7. ___List of Allergies  ___Other Diagnostic Reports (Specify)_______________________

8. ___Other (Specify)____________________________________

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.

Yes __________  I consent to the release of this information.  No __________  I do not consent to the release of this information.

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 expires upon completion of this request or upon the following date:________________________________________________________

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 ________________________________ ________________________________

(insert privacy officer or other office or individuals name or contact information)

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 notes 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 _______ 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 __________________________

Date request completed_________________  # pages copied_________________  Reviewed only______________

Charges $__________________  Cash__________  Check #__________________  Initials__________

* [All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted – with the advice of the organization’s attorney – to meet state, local, individual organizations and department needs or requirements. They are distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services.]
Appendix 11.
Fax cover letter

SAMPLE

Your letterhead

CONFIDENTIAL INFORMATION
FAX COVER LETTER

DATE: ___________ TIME: _______________ a. m., p.m.   NO. OF PAGES_______

TO: ____________________________________________

______________________________________________

(authorized receiver’s name)

______________________________________________

(authorized receiver’s facility name and address)

PHONE: _________________________  FAX: ____________________________

______________________________________________  ____________________________

(authorized receiver’s phone)  (authorized receiver’s fax)

FROM: _________________________________________________________________

______________________________________________

(sender’s name)

______________________________________________

(sender’s facility name and address)

PHONE: _________________________  FAX: ____________________________

______________________________________________  ____________________________

(sender’s phone)  (sender’s fax)

COMMENTS:

PLEASE NOTE: The information contained in this facsimile message may be privileged and confidential, and is intended only for the use of the individual named above and others who have been specifically authorized to receive it. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, or if any problems occur with this transmission, please notify us immediately by telephone: _____________ and return the original message to us at the address above via the United States Mail. Thank you.
## Appendix 12.
### Message pad

**SAMPLE**

<table>
<thead>
<tr>
<th>To</th>
<th>Date</th>
<th>Time</th>
<th>am pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caller:</td>
<td>Patient Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone #:</td>
<td>Allergies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Name:</td>
<td>Pharmacy Phone #:</td>
<td>Refill Y N</td>
<td></td>
</tr>
<tr>
<td>Complaint:</td>
<td></td>
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</tr>
</tbody>
</table>

**Instructions:**

**Prescriptions:**

**Physician Signature:**

*Moisten & file in patient’s office record*  
*TMLT: PROTECTING TEXAS PHYSICIANS*
Appendix 13.
Informed refusal

SAMPLE

Your letterhead

In order to diagnose/treat my condition a ___________________________________ was
(test/procedure)

ordered for me on __________________. The reasons for ordering this test/
(date)

procedure have been carefully explained to me. I understand the potential benefits are:

________________________________________________________________________

________________________________________________________________________

and the alternatives include___________________________________________________.

In addition, Dr. ______________________________ has informed me of the risks
involved in not having a ____________________________ performed. These risks
(test/procedure)

include ___________________________________________________________________

________________________________________________________________________

After careful consideration of the benefits and risks concerning the above, I am refusing
(test/procedure)

_________________________________. My reason(s) for refusing is____________________

________________________________________________________________________

________________________________________________________________________

____________________________________       ________________________________
Patient signature                  Witness signature

____________________________________       ________________________________
Date                                Date
<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT NAME</th>
<th>TEST</th>
<th>FACILITY</th>
<th>DATE RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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Appendix 15.
Email policy

SAMPLE

E-mail policy

Purpose: To provide a procedure for the appropriate use and handling of email communications with patients.

Policy: To provide for patient satisfaction, when requested this office will communicate some forms of information via email. This medium will be used with an eye towards medical and legal prudence.

Procedure:
1. Email communications will only be used with established patients.

2. Patients who elect to use email must be advised of this office's email policy and sign an informed consent (see attached).

3. A copy of the consent will be given to the patient and a copy filed in the medical record.

4. Automatic reply to all incoming messages will state: “Your message has been received by [your practice name]. I will attempt to process your request within one business day. If you need immediate assistance, please call my nurse at [your phone number].”

5. All email involving patients or written to patients must be filed in the patient's medical record.

6. Patient issues which are not discussed via email are:
   - protected diagnoses such as psychiatric conditions
   - results of HIV testing
   - work-related injuries and disability

7. Turnaround time: The [insert job title] is responsible for checking and routing incoming email on a [insert time frame, such as daily basis]. (Should be an employee with a clinical background if triage involved.)

8. When a patient request has been completed, the staff member responsible for completing that task will be responsible for sending a confirmation message to the patient.
9. As with any form of medical record documentation, unprofessional remarks or comments in email communications are prohibited.

10. Confidentiality of patient information will be maintained at all times.

11. When sending sensitive patient information via email, the sender is expected to double check all “to” fields before transmitting.

12. If sending group mailings, the “blind cc” feature must be used.

13. Outgoing messages will contain discreet subject headers and a banner at the top of each message stating, “This is confidential medical communication.”

14. Each desktop workstation will have a password-protected screen saver.

15. Mail will be backed up [at least weekly] onto [long-term storage medium].

16. The [insert job title] will activate the out-of-office assistant any time the email account will not be serviced by the staff or covering physicians during an absence that exceeds the established email response time.
Patient guidelines and consent for use of email communications

SAMPLE

Your letterhead

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

Types of communication that are appropriate for e-mail include:

- scheduling inquiries
- non-urgent medical advice
- billing or insurance questions
- educational materials
- test and lab results
- home and health monitoring reports
- prescription refill requests (per policy)

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Some issues (e.g. HIV, mental health, work-related injuries and disability) are not appropriate for email. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of email 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. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

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 e-mail policy.

_____________________________  _______________________
Patient signature  Witness (optional)

_____________________________  _______________________
Date  Date
XI. WEB SITES FOR REFERENCE

Texas Medical Liability Trust
www.tmlt.org

Texas Medical Association
www.texmed.org

Texas Medical Board
www.tmb.state.tx.us

Texas Department of State Health Services
www.dshs.state.tx.us

Texas Health Information Management Association
www.txhima.org

Center for Medicare and Medicaid Services
www.cms.gov

HIPAA
www.hipaadvisory.com

OSHA
www.osha.gov

Food and Drug Administration
www.fda.gov

American Medical Association
www.ama-assn.org
XII. GLOSSARY OF INSURANCE TERMS

**Actuary** — a mathematician who uses statistical analysis to compute insurance risks and premiums.

**Captive insurance company** — a provider-owned insurance company, where the provider may be a hospital or a group of physicians.

**Carrier** — an insurance company.

**Claim** — in common language, any demand for compensation, etc.

**Declaration page** — the front sheet of the insurance policy that defines effective dates and times of the policy, the limits of the policy, the premium amount and the named insured.

**Experience rating** — the practice of basing insurance premiums on past loss history.

**Frequency of claims** — refers to the number of claims that are filed. Frequency and average severity of claims are the fundamental variables used in determining insurance premiums. (See Severity of a claim)

**General liability insurance** — a type of liability insurance other than automobile, worker’s compensation or employer’s liability that covers damage or bodily injury. In a health care setting, general liability would cover such incidents as a visitor slipping on a wet floor of a hospital or office, or the theft of a patient’s belongings.

**Indemnity** — refers to a total shifting of the economic loss to the party directly responsible for that loss. To indemnify is to compensate for damage, loss or injury.

**Indemnity agreement** — an agreement whereby one party attempts to shift responsibility for economic loss or potential liability.

**Insurance** — a contractual relationship (policy) which exists when one party (insurance company or carrier) in consideration of a fixed sum (premium) agrees to reimburse another (insured or policyholder) for loss caused by designated contingencies. (See “Policy”)

**Insurance company** — a company, also known as a provider or carrier, that is licensed by a state to sell some or all types of insurance. There are several types of insurance companies including, but not limited to stock companies or mutual companies.

**Insurance exchange** — an association of insurance policyholders, also known as a reciprocal exchange, in which the policyholders join together and “exchange” their rights and obligations, thereby insuring one another.
Limits of coverage — the maximum amount an insured can collect under the terms of a policy. Professional liability policies typically specify limits per claim and cumulative limit for all claims incurred during the term of a contract, e.g., “$1 million (per claim)/$3 million (per term).”

Nose coverage — a supplement to a “claims-made” policy that may be purchased from a new carrier when the policyholder changes carriers and had claims-made coverage with a previous carrier. A nose policy, also known as “prior acts” coverage, covers incidents that occurred prior to the beginning of the new insurance relationship, but have not yet been brought as a claim. Nose coverage is an alternative to an “extended reporting endorsement” also known as “tail coverage” which is purchased from the original carrier when a change in carriers is made.

Policy — the contractual agreement between an insurance company and its insured. The policy sets forth the rights and obligations of both parties to the agreement.

Premium — the amount of money an insured pays for an insurance policy. The premium is calculated by the insurance company’s underwriters to bring in enough money to establish reserves for future losses, pay current losses, cover the company’s operating expenses including the cost of defending claims, and generate a profit if the company is organized as a profit making business.

Premium credits — a reduction in premium that acknowledges an expected reduction in risk due to claims history, completion of a risk management course or a variety of other factors.

Prior acts — an insurance term referring to incidents occurring before the coverage with a new company begins, but have not yet been filed as claims. Companies typically require the new insured to purchase either supplemental “tail” or “nose” coverage to protect against claims arising from prior acts.

Rate — an insurance term reflecting the basis or classification upon which the premium is based, often used as synonym for premium.

Reinsurance — a contract whereby an insurance company will itself buy insurance from a second company (the reinsurer) to cover part of the risk the first company has insured. The amount of risk a company will reinsure varies from carrier to carrier.

Reporting requirement — the contractual obligation of the insured to promptly report any claim for damages asserted against the insured. What constitutes a claim that must be reported varies from company to company but is always defined in the policy.

Reservation of rights — an insurance term that refers to the situation arising when there is a question as to whether there is coverage for an incident. Typically, an insurer is
obligated to defend a claim during the time the coverage question between the insurer and policyholder is being resolved.

**Reserve** — money set aside and invested by insurance companies to pay estimated future losses. A company’s claim department typically specifies a reserve amount for every claim that is filed, which may be modified as the claim proceeds.

**Risk classification** — an insurance term referring to a classification based on the actual and predicted number and size of losses that can be expected from a physician’s specialty and procedures, which is used in determining the premium to be charged.

**Risk purchasing group** — a group or entity permitted by federal law to organize across state lines to buy insurance. The insurer selling to the group must be licensed in at least one state, but need not be licensed in every state where a member of the group resides.

**Severity of a claim** — also known as claim magnitude, this is the dollar value of a claim as determined by jury verdict or settlement agreement. Claim frequency and claim severity are the principal variables used in determining insurance premiums.

**Syndicated insurance company** — a company organized by a group of entities who each agree to share in selling insurance to the syndicates’ policyholders and pledge their personal assets to cover the losses of the policyholder.

**Underwriting** — the process by which a company evaluates and classifies risks, and measures and calculates the cost of protection, within the framework of the rules, rates and coverage forms that are permitted by law in a particular state.
XIII. GLOSSARY OF MEDICAL-LEGAL TERMS

Abandonment — a legal term referring to the termination of a physician-patient relationship by the physician without reasonable notice and without an opportunity for the patient to acquire adequate medical care elsewhere. If the abandonment results in some type of damage to the patient, it may constitute medical malpractice.

Admissibility (in evidence) — refers to evidence that may be properly received and considered in a legal proceeding. The determination as to admissibility is based on legal rules of evidence and is made by the trial judge.

Admission against interest — statements made by a party to a lawsuit that are indicative of his or her own guilt. An admission against interest is admissible in evidence as an exception to the hearsay rule. (See Hearsay Rule.)

Affidavit — voluntary, written statement of facts made under oath before an officer of the court or before a notary public.

Allegation — statement of a party to an action, made in a pleading, setting out what the party expects to prove.

Answer — a document filed with the court that contains a defendant’s response to allegations set forth in the plaintiff’s complaint. (See Complaint.)

Battery — the unauthorized and intentional touching of a person by another. In medical malpractice cases, battery typically refers to contact of some type with a patient who has not granted an informed consent to the contact. Battery can be either a criminal or civil offense.

Breach of contract — failure without legal excuse to complete or perform any promise which forms the whole or part of a legally binding contract.

Burden of proof — the responsibility in a legal proceeding of presenting sufficient evidence to prove a fact or facts in dispute. The plaintiff typically has the burden of proof.

Captain of the ship — a legal doctrine which holds one responsible for acts of those under his/her supervision and control. Most commonly used when the physician in charge of a medical team is liable for all of the negligent acts of the members of the team.

Causation — a legal term referring to the causal connection between the defendant’s alleged breach of duty and the injury suffered by the plaintiff. It is necessary to show causation in order to prove negligence. (See Negligence, Proximate Cause.)
**Cause of action** — a set of alleged facts that forms the basis for a plaintiff to file a complaint.

**Collateral source rule** — a rule of law that prevents the admissibility of any evidence about or the subtraction from the damage award of any payments that the plaintiff has received from such collateral sources as workers’ compensation, health insurance, government benefits, or sick pay benefits.

**Comparative negligence** — a legal doctrine that attempts to apportion liability for an injury or loss according to the amount of fault attributable to each responsible person, including each defendant, any potential defendants not named in the lawsuit, and the plaintiff. In some jurisdictions, the comparative negligence of the plaintiff may be used as an affirmative defense to reduce the amount of damages, generally by an amount equal to the plaintiff’s percentage of fault. Most states have adopted some form of comparative fault.

**Complaint** — a legal document that is the initial pleading filed by the plaintiff in a civil lawsuit. A complaint, sometimes known as a declaration, gives a defendant notice of the alleged facts constituting the cause of action. The complaint, accompanied by the summons, is served on the defendant by a process server or, in some states, by certified mail.

**Contributory negligence** — a legal doctrine that has been supplanted in most states by the doctrine of comparative negligence. The old rule held that the contributory negligence of a plaintiff in any amount could be asserted as an affirmative defense by the defendant, completely barring recovery of damages by the plaintiff. In contrast, comparative negligence only reduces the amount of damages owed to the plaintiff.

**Damages** — the sum of money a court or jury awards as compensation for a tort or breach of contract. The law recognizes certain categories of damages, including general, special, and punitive/exemplary damages.

**General damages** — typically intangible damages such as pain and suffering, disfigurement, interference with ordinary enjoyment of life, and loss of consortium (marital services).

**Punitive/exemplary damages** — damages awarded to the plaintiff in cases of intentional tort or gross negligence to punish the defendant or act as a deterrent to others.

**Special damages** — out of pocket damages that may be quantified, such as medical expenses, lost wages and rehabilitation costs.

**Defamation** — the willful injuring of another person’s reputation or character by false and malicious statements, either written, liable or spoken slander. Like negligence and battery, defamation is a tort.
**Deposition** — a discovery procedure whereby each party may question another party or anyone who may possibly be a witness. Depositions are conducted before the trial, under oath, and are admissible at trial under certain circumstances.

**Discovery** — pretrial procedures to learn of evidence in the possession of an opposing party in order to minimize the element of surprise at the time of trial.

**Duty** — an obligation, recognized by the law. A physician’s duty to a patient is to provide the degree of care ordinarily exercised by physicians.

**Guardian** — individual recognized by law or appointed by the court to manage the affairs or protect the legal interests of one who is incompetent by reason of age, physical or mental status, and is, therefore, considered incapable of managing his/her own affairs.

**Here say rule** — an out-of-court statement offered as evidence to prove the truth of the facts contained in the statement. Here say is generally not admissible. There are, however, many exceptions to the here say rule.

**Immunity from liability** — legally granted freedom from responsibility for damages due to an act or omission that ordinarily would impose such liability. Generally, immunity is awarded only in a narrow range of circumstances necessary to achieve some important public good. Good Samaritan statutes are an example.

**Interrogatories** — a “discovery” procedure in which one party submits a series of written questions to the opposing party who must answer in writing, under oath, within a certain period of time. The answers are admissible at trial under certain circumstances.

**Joint and several liability** — a legal doctrine designed to protect the plaintiff from insolvent defendants, whereby each individual defendant in a lawsuit is responsible for the entire amount of damages awarded against all defendants. Generally, a defendant who is forced to pay more than his share has the right to file a cross-claim against other defendants for contribution.

**Liability** — obligation that a person has incurred or might incur through any breach of a legally enforced duty; responsibility for conduct falling below a certain standard which is the causal connection of the plaintiff’s injuries.

**Locality rule** — the test historically used by courts to determine the standard of care owed by health care providers to patients. The rule holds that health care providers have the duty to render care consistent with the care of other competent or prudent practitioners under the same or similar circumstances in the same or similar community. Most states have displaced the locality rule with the requirement that care must be consistent with national standards. (See Standard of care.)

**Loss of consortium** — a claim for damages by the spouse of an injured party for the loss of services, comfort, society, and interference with sexual relations.
Negligence — a tort which is proven by showing (1) the existence of a duty owed to the plaintiff's; (2) breach of the duty by the defendants and (3) an injury that (4) was caused by the breach. In medical malpractice cases, the breach of duty element is proved by showing that a health care provider failed to exercise the standard of care practiced by a reasonably prudent health care provider with similar training under similar circumstances.

Pain and suffering — element of non-economic damages (i.e. not related to out-of-pocket expenses) that allows compensation for mental anguish and/or physical pain endured by the plaintiff in connection with the injury for which the plaintiff is seeking redress.

Petition — a legal document that is the initial pleading filed by the plaintiff in a civil lawsuit. A complaint, sometimes known as a declaration, gives a defendant notice of the alleged facts constituting the cause of action. The complaint, accompanied by the summons, is served on the defendant by a process server or, in some states, by certified mail.

Proximate cause — an act or omission that, unbroken by any intervening cause, produces an injury. Proximate causation is one of the four elements that a plaintiff must prove in a negligence claim. In a medical malpractice case, failure to adhere to the standard of care must be the proximate cause of the injury to the patient.

Res ipsa Loquitur — “The thing speaks for itself.” A case in which the personal injuries and/or property damage would not have occurred without negligence. In medical malpractice cases, it allows a patient to prove his/her case without the necessity of an expert witness to testify that the defendant physician violated the standard of care. It is applicable only in those instances in which negligence is clear and obvious, even to a layperson, such as a case in which a surgeon leaves a sponge or other foreign object in the patient following surgery.

Respondeat superior — “Let the master answer.” The legal principle that makes an employer liable for civil wrong, including negligence, committed by employees within the course and scope of their employment.

Standard of care — a term used in the legal definition of medical malpractice. A physician is required to adhere to the standards of practice of reasonably competent physicians, in the same or similar circumstances, with comparable training and experience.

Statute of limitations — the time period established by law in which a plaintiff may file a lawsuit. Once this period expires, the plaintiff's lawsuit is barred if the defendant asserts the affirmative defense of the statute of limitations.
**Summary judgment** — granting a judgment in favor of either party prior to trial. Summary judgment is only granted when there is no material fact in dispute and one of the parties is entitled to judgment as a matter of law.

**Survival action** — a statutory action for money damages that exist in the favor of the estate of a person when the person dies due to the acts or omissions of another.

**Vicarious liability** — civil liability for the torts of others. Physicians may be vicariously liable for the negligent acts of their employees committed within the scope of their employment (See Respondeat superior). In the hospital setting, a surgeon may be vicariously liable for the negligent acts of all members of the surgical team (See Captain of the ship).

**Wrongful Birth** — an action recognized in some states that allows parents to seek damages after the birth of an impaired child on the theory that if they had received proper genetic counseling or testing, the child's birth could have been avoided.

**Wrongful death** — an action for money damages that exist in favor of the surviving spouse, children, parents or estate when a person dies due to the wrongful acts of another.

**Wrongful life** — an action brought by an impaired child who contends that if his/her parents had been correctly counseled about likely birth defects, he/she would have never been conceived or would have been aborted.