



P A N H A N D L E  
P R I M A R Y C A R E

## Cindy I Hutson DO PA

### Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F

Marital Status: Married Single Divorced Widowed

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Full-time / Part-time

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is it okay to leave a message at work? Y N Are you a student? Y N Full-time / Part-time

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

### Spouse Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance (Primary) NAME: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Birth Date: \_\_\_\_\_

Policy Holder Phone #: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Insurance (Secondary) NAME: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Birth date: \_\_\_\_\_

Policy Holder Phone #: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Emergency Contact (Not living in household preferred, but not limited to):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



# FINANCIAL POLICY

## Panhandle Primary Care

Welcome to Panhandle Primary Care! We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

### PARTICIPATING PROVIDER

We are providers for several networks and Medicare Part B. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. **Therefore, it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list before making an appointment.** You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan.

For non-contracted plans, you will need to pay in full and file your own claim.

**YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.**

### CO-PAYMENTS

We require your co-payment at check-in. We will verify insurance and collect payment based on the information provided by your insurance company.

### DEDUCTIBLE AND COINSURANCE

If you have a deductible, we will verify insurance and collect payment based on the information provided by your insurance company. We collect deductible, co-insurance and any balance owing at each visit.

### REFERRALS, PRECERTIFICATION, AND PRE-AUTHORIZATIONS

Referrals, precertification, and pre-authorization of additional medical services is an area in which we strive to help you. Due to the varying policy provisions of all of our patients plans, it is impossible for us to know each patients specific plan provisions. **If you fail to disclose precertification requirements PRIOR to services being rendered, you may be responsible for payment of all related fees in full.**

**IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN FOR X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES.**

### SECONDARY INSURANCE

We will file secondary insurance as a courtesy to you. Please keep in mind that payment of your account is ultimately your responsibility. We will look to you for payment, if we are unsuccessful in obtaining reimbursement by your insurance.

### RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Panhandle Primary Care to become involved in medical bill payment disputes resulting from divorce, etc.

### NSF CHECKS

Checks returned for NSF, will have a \$35.00 fee added.

**LIABILITY OR AUTO ACCIDENT CLAIMS**

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed. You may contact our office for a copy of HCFA.

**WORKER'S COMPENSATION CLAIMS**

We do not participate in Worker's Compensation and are unable to file claims on your behalf. We do not see patients for any work related injuries.

**BILLING OF ACCOUNT BALANCES**

You will receive a statement for which payment is due upon receipt.

**No-Show / Cancelled & Rescheduled Appointments**

We ask that you provide us with a 24-hour notice of cancellation or rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of \$45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments.

**NON-PAYMENT OF ACCOUNTS**

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

**CONSULTATION WITH YOUR OWN ATTORNEY:**

AGREEMENT AS TO GOVERNING LAW AND FORUM: The patient and health care provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by the Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas District Court in the county where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state or in any Federal Court. The choice of law and forum selection provisions of this paragraph is mandatory and is not permissive.

<b><u>ACCEPTANCE OF FINANCIAL POLICY</u></b>	
The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Panhandle Primary Care.	
_____	
Signature of Patient or Legal Guardian	Date

<b><u>ASSIGNMENT OF BENEFITS</u></b>	
The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to Panhandle Primary Care office provider who rendered services on their Behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.	
_____	
Signature of Patient or Legal Guardian	Date

**CINDY HUTSON DO PA  
PANHANDLE PRIMARY CARE / AMARILLO HEADACHE CLINIC  
NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU  
CAN GET ACCESS TO THIS INFORMATION**

**PLEASE REVIEW IT CAREFULLY  
EFFECTIVE 02-16-2026**

**OUR COMMITMENT TO YOUR PRIVACY**

Panhandle Primary Care / Amarillo Headache Clinic is committed to protecting the privacy of health information. We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of Privacy Practices (Notice) of our legal duties and privacy practices regarding your PHI, and follow the terms of the Notice currently in effect

This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information. The privacy practices described in this Notice will be followed by all members of the workforce at Panhandle Primary Care / Amarillo Headache Clinic, including health care professionals, employees, trainees, students, and volunteers. Additionally, third parties (“business associates”) that provide services on our behalf will be required to comply with all applicable provisions.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

The following sections describe different ways we may use and disclose your health information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure is listed. All of the ways we are permitted to use and disclose health information, however, will fall within one of the following categories:

**TREATMENT**

We may use and disclose your health information to provide, coordinate, or manage your healthcare and related services. This includes consultation with other healthcare providers regarding your treatment and referral to another provider. For example, your primary care physician may share your health information with a specialist to coordinate your care.

**PAYMENT**

We may use and disclose your health information to obtain payment for services we provide. This includes billing activities, claims management, and collection activities. For example, we may send claims to your health insurance company containing certain health information to obtain payment for services we provided.

**HEALTHCARE OPERATIONS**

We may use and disclose your health information for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost-effectiveness of care. For example, we may use health information to evaluate the performance of our staff, assess the quality of care, or conduct training programs.

**SUBSTANCE ABUSE TREATMENT**

We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records (“Part 2”), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission. You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

Ryan R. Raybould  
500 S. Taylor St., Suite 300  
(Amarillo National Plaza II)  
Amarillo, TX 79101

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at [OTP-extranet@opiod.samhsa.gov](mailto:OTP-extranet@opiod.samhsa.gov).

#### **OTHER USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR AUTHORIZATION:**

As Required by Law. We may disclose health information when required by federal, state, or local law.

- **Law Enforcement.** We may disclose health information to law enforcement officials for law enforcement purposes as permitted by law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose health information to coroners, medical examiners, and funeral directors to carry out their duties.
- **Organ and Tissue Donation.** We may disclose health information to organizations involved in the procurement, banking, or transplantation of organs, eyes, or tissue.
- **Research.** We may use or disclose health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **To Avert a Serious Threat to Health or Safety.** We may use or disclose health information when necessary to prevent a serious threat to the health or safety of you, another person, or the public.
- **Specialized Government Functions.** We may disclose health information for military, national security, protective services, or correctional institution purposes as authorized by law.
- **Workers' Compensation.** We may disclose health information as authorized by workers' compensation laws. • Unless you say no, to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify.

#### **USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION:**

We will obtain your written authorization before using or disclosing your health information for purposes other than those described above. Specifically, we will obtain your authorization before using or disclosing:

- Psychotherapy notes (with limited exceptions)
- Health information for marketing purposes
- Health information in a manner that constitutes a sale of PHI

Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your health information without your written authorization. If you provide us with authorization to use or disclose your health information about you, you may revoke your authorization, in writing, at any time.

However, uses and disclosures made before the revocation of your authorization are not affected by your action and we cannot take back any disclosures we may have already made with your authorization or that may have been made on reliance of your authorization.

#### **USE OF UNSECURE ELECTRONIC COMMUNICATIONS**

If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication.

In addition, if you provide your email address or cell phone number to a health care provider, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices.

By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that the use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights regarding the health information we maintain about you:

**RIGHT TO INSPECT AND COPY** You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care, including medical and billing records. To inspect or copy your health information, submit a written request to our Privacy Officer. We may charge a reasonable fee for copying and mailing costs.

**RIGHT TO AMEND** If you believe that information in your record is incorrect or incomplete, you may request that we amend it. To request an amendment, submit a written request to our Privacy Officer that includes the reason for your request. We may deny your request in certain circumstances, and if we do, we will provide you with a written explanation.

**RIGHT TO AN ACCOUNTING OF DISCLOSURES** You have the right to receive a list of certain disclosures we have made of your health information. To request an account, submit a written request to our Privacy Officer specifying the time period for which you want the accounting (not to exceed six years). The first accounting in a 12-month period will be provided free of charge; subsequent requests may incur a reasonable fee.

**RIGHT TO REQUEST RESTRICTIONS** You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations, or to restrict disclosures to family members or others involved in your care. We are not required to agree to your request except in one situation: if you pay for a service or item out of pocket in full, you can ask us not to share information about that service or item with your health insurer for payment or healthcare operations purposes, and we will honor that request.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request confidential communications, submit a written request to our Privacy Officer specifying how or where you wish to be contacted. We will accommodate reasonable requests.

**RIGHT TO A PAPER COPY OF THIS NOTICE** You have the right to a paper copy of this Notice of Privacy Practices at any time. We have copies available at the front desk or you may also obtain a copy of this Notice by visiting [panhandleprimarycare.com](http://panhandleprimarycare.com) / [headacheclinicamarillo.com](http://headacheclinicamarillo.com) or by contacting our Privacy Officer at the address provided at the end of this Notice.

**RIGHT TO BE NOTIFIED OF A BREACH** You have the right to be notified in the event that we discover a breach of your unsecured health information. Right to a Paper Copy of this Notice.

**CHANGES TO THE TERMS OF THIS NOTICE** We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our facility, and on our web site.

### **COMPLAINTS**

If you have any questions about this Notice or our privacy practices, or if you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address and phone number below. You will not be retaliated against for filing a complaint. you wish to exercise your HIPAA rights or make a complaint, please contact our Privacy Officer.

#### **CONTACT INFORMATION**

Cindy Hutson DO PA  
Attn: Ashley Belter  
2703 Mockingbird Lane  
Amarillo TX 79109  
806-351-2000

[ashleybelter@panhandleprimarycare.com](mailto:ashleybelter@panhandleprimarycare.com)

#### **TO FILE A COMPLAINT WITH HHS**

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201  
1-877-696-6775

[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

**VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.**

By signing below, you acknowledge that you have received the *Notice of Privacy Practices* ("Notice") effective February 16, 2026 prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient Name: \_\_\_\_\_  
(Please Print Name)

Patient Date of Birth: \_\_\_\_\_

**SIGNATURES:**

Please sign if Patient or Legal Representative: \_\_\_\_\_

**Date:** \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

Witness (optional): \_\_\_\_\_ **Date:** \_\_\_\_\_

Your medical information will not be released to anyone other than yourself or your designated representative. **If you wish for a family member or other representative to have access to your information, please list their names below:**

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

I hereby request the following restrictions for the people listed above, on the use and/or disclosure (specify as applicable) of my information:

\_\_\_\_\_  
\_\_\_\_\_



P A N H A N D L E  
PRIMARY CARE

**Cindy Hutson, DO, PA**

2703 Mockingbird Lane

Amarillo, TX 79109

(806)351-2000

FAX (806) 351-2060

We ask that you provide us with a 24-hour notice of cancellation / rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of \$45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments

**Cancellations can be made by:**

- Phone – 806.351.2000 (please leave if message if not during office hours)
- Patient Portal (Healow) Message
- Email – [danaratliff@panhandleprimarycare.com](mailto:danaratliff@panhandleprimarycare.com)

**ANY QUESTIONS ABOUT CHARGES CAN BE DIRECTED TO  
[ashleybelter@panhandleprimarycare.com](mailto:ashleybelter@panhandleprimarycare.com)**

We understand everyone's schedule is hectic and that changes can arise quickly and unexpectedly. We value your time and will do our best to accommodate your scheduling needs. We appreciate you being considerate of our time and providing advanced notice if you are unable to keep your scheduled appointment so we may accommodate other patients.

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Signature of Patient or Legal Guardian

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Date

PATIENT NAME: \_\_\_\_\_

**FAMILY HISTORY:** ( list A = alive, if alive and list health history or D = deceased, if deceased and list cause of death ):

Father (DOB): \_\_\_\_\_ Mother (DOB): \_\_\_\_\_

Paternal Grandfather: \_\_\_\_\_ Paternal Grandmother: \_\_\_\_\_

Maternal Grandfather: \_\_\_\_\_ Maternal Grandmother: \_\_\_\_\_

**LIST TOTAL NUMBERS BELOW:**

Brothers: \_\_\_\_\_ = \_\_\_\_\_ Alive; \_\_\_\_\_ Deceased    Sisters: \_\_\_\_\_ = \_\_\_\_\_ Alive; \_\_\_\_\_ Deceased

Sons: \_\_\_\_\_ = \_\_\_\_\_ Alive; \_\_\_\_\_ Deceased    Daughters: \_\_\_\_\_ = \_\_\_\_\_ Alive; \_\_\_\_\_ Deceased

**PLEASE ANSWER (Y = yes or N = no):**

	Living Will		Seatbelts
	Fall Risk		Smoke/Vape
	Alcohol		Caffeine
	Exercise		Recreational Drugs
	Sexually Active		

**YEAR OF LAST:**

Tetanus Shot: \_\_\_\_\_ TB Test: \_\_\_\_\_ Flu Vaccine: \_\_\_\_\_ Shingles: \_\_\_\_\_

Pneumovax: \_\_\_\_\_ Prevnar 13: \_\_\_\_\_

Last Colonoscopy / Cologuard: \_\_\_\_\_ Due: \_\_\_\_\_

Last EGD: \_\_\_\_\_ Due: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_ Due: \_\_\_\_\_

Last Bone Density: \_\_\_\_\_ Due: \_\_\_\_\_

Last Pap (Females Only): \_\_\_\_\_ Due: \_\_\_\_\_

Last PSA/DRE (Males Only): \_\_\_\_\_ Due: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Specialists that you currently see: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Chronic Medical Conditions: \_\_\_\_\_

\_\_\_\_\_



**Are you a:**

- Current Smoker / Vaper
- Former Smoker / Vaper
- Never Smoked / Vaped
- Current every day smoker / vaper
- Current some day smoker / vaper
- Smoker / Vaper, current status unknown
- Unknown if ever smoked / vaped

**If Former Smoker / Vaper: How long has it been since you last smoked?**

- 1-3 month
- <1 month
- 3-6 months
- 6-12 months
- 1-5 years
- 5-10 years
- >10 years

**If current smoker / vaper: How often do you smoke cigarettes**

- Everyday
- Some days, but not everyday

**If current smoker / vaper: How many cigarettes a day do you smoke?**

- 5 or less
- 6-10
- 11-20
- 21-30
- 31 or more

**If current smoker / vaper: How soon after you wake up do you smoke your first cigarette?**

- Within 5 min
- 6-30 min
- After 60 min

**If current smoker / vaper: Are you interested in quitting?**

- Ready to quit
- Thinking about quitting
- Not ready to quit

**If current smoker / vaper: When was your last chest x-ray? \_\_\_\_\_**