

Texas Spine & Joint Hospital Confidentiality Agreement

Texas Spine and Joint Hospital (TSJH) has legal and ethical responsibilities to safeguard the privacy of its employees, patients, and their families and to protect the confidentiality of protected health information and all other types of confidential information. Members of the TSJH community include but are not limited to:

- TSJH Workforce Member: an individual performing work on behalf of TSJH and under the direct control of TSJH, whether or not the member is employed by TSJH. Examples include: staff; temporary agency workers, physicians, contractors, students, and volunteers.
- Extended Community Member: an individual who is present on TSJH premises or is accessing information resources at TSJH for a specific treatment, payment, or health care operation business purpose allowed under the Health Insurance Portability and Accountability Act (HIPAA) such as a third party payer representative, a visitor for a guided tour or observation experience, media or vendor representatives, or other health care providers involved in a patient's continuum of care.
- Business Associate: is a person or company that performs certain functions or activities on behalf of, or for, TSJH that involve the creation, use or disclosure of TSJH protected health information.

As a member of the TSJH community, I agree to conduct myself in strict conformance with all applicable laws and with TSJH's policies governing confidential information. I understand and agree that measures must be taken so that all confidential information captured, maintained, or utilized by TSJH and any of its off-site facilities is accessed only by authorized users. These obligations apply to confidential information that is collected or maintained verbally, in paper, or electronic format.

TSJH confidential information includes any and all of the following categories:

- Patient information including demographic, health, and financial information (in paper, verbal, or electronic form regardless of how it is obtained, stored, utilized, or disclosed);
- Information pertaining to members of the TSJH Workforce or Extended Community (such as social security numbers, banking information, salaries, employment records, disciplinary actions, etc.);
- TSJH information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary information including computer programs, source code, proprietary technology, etc.);
- Third-party information (such as insurance, business contracts, vendor proprietary information or source code, proprietary technology, etc.); and

As a condition of and in consideration of my use, access, and/or disclosure of confidential information, I agree that:

1. I will access, use, and disclose confidential information only as authorized and needed to perform my assigned job duties. This means, among other things, that I:
 - a) will only access, use, and disclose confidential information that I have authorization to access, use, and disclose in order to perform my job duties;
 - b) will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly and clearly authorized within the scope of my job duties and as in accordance with all applicable TSJH policies and procedures and with all applicable laws;
 - c) will report to my supervisor or to the appropriate office any individual's or entity's activities that I suspect may compromise the privacy or security of TSJH confidential information.

2. If I am granted access to TSJH electronic systems, including email, I am the only person authorized to use the individual user identification names and passwords or access codes assigned to me. I agree to the following:
- a) To safeguard and not disclose my individual user identification passwords, access codes or any other authorizations which allow me to access TSJH confidential information to anyone including my manager.
 - b) To not request access to or use any other person's passwords or access codes.
 - c) I accept responsibility for all activities undertaken using my passwords, access code and other authorizations.
 - d) It is my responsibility to log out of any system to which I have logged on. I will not under any circumstances leave unattended a computer to which I have logged on without first either locking it or logging off the workstation.
 - e) If I have reason to believe that the confidentiality of my password has been compromised, I will immediately change my password.
 - f) I understand that my user identification will be deactivated upon notification to Information Management that I am no longer a TSJH Workforce Member, Extended Community Member, or Business Associate; or when my job duties no longer require access to the computerized systems.
 - g) I understand that TSJH has the right to conduct and maintain an audit trail of all accesses to confidential information, including the machine name, user, date, and data accessed and that TSJH may conduct a review of my system activity at anytime and without notice in order to monitor appropriate usage.
 - h) I understand and accept that I have no individual rights to or ownership interests in any confidential information referred to in this agreement and that therefore TSJH may at any time revoke my passwords or access codes.
 - i) I understand that individuals who access TSJH confidential information from home must follow TSJH's security guidelines for remote access.
 - j) I understand that it is my responsibility to be aware of TSJH's Human Resource policies, and any other policies that specifically address the handling of confidential information and misconduct that warrants immediate discharge.

My signature below indicates that I have read, accept, and agree to abide by all of the requirements described above. I acknowledge that any violation of these requirements may result in disciplinary measures up to and including termination of employment and/or affiliation with TSJH.

Signature: _____

Date: _____

Printed Name: _____

Job Title: _____

Department: _____

Texas Spine & Joint Hospital

CONSENT FOR AUTHORIZATIONS AND RELEASES

Your signature below signified that you agree to the following conditions pertaining to this application.

1. I attest to the correctness and completeness of all information furnished.
2. I am willing to appear for interviews in connection to this application.
3. I agree to abide by the terms of any bylaws, rules, regulations, policies and procedure manuals of Texas Spine & Joint Hospital, presently formulated or as later amended or modified.
4. I authorize a representative of Texas Spine & Joint Hospital to consult associates or others, who may have information bearing on my qualifications and consent to their inspecting records and documents that may be material to the evaluation of my qualification and competence.
5. I release from any liability all those who, in good faith, review, act on or provide information regarding my competent, professional ethics, character, health status and other qualifications for clinical privileges.
6. I authorize any healthcare facility to release copies of my privileges and staff application to Texas Spine & Joint Hospital.
7. I authorize any medical school or healthcare facility to release information on my medical training.
8. I agree to provide the Medical Director/Administrator of Texas Spine & Joint Hospital of any change in the information submitted in this application within thirty days of such change.

Signature

Date

Printed Name

Social Security Number

Texas Spine & Joint Hospital

Professional Staff Continuing Education Verification

Please submit documentation of your continuing education for the past year.

The following options are offered:

- 1) List the courses taken, location, date and number of CEUs or contact hours obtained. If necessary, attach additional pages(s).
- 2) Forward a copy of your own listing. Copies of certificates may be submitted, but are not required.
- 3) Certify that you have the required CEU's for the State of Texas and will provide them upon request.

Course Taken	Location	Date	CEU/Contact Hrs.

*** I hereby certify I have completed the required continuing education needed to maintain my license and/or certificate. I understand a random audit will be done at which time I will bring proof of the education listed above. The record will be maintained in my file.

Printed Name/Title

Signature/Title

Date

DOCUMENTS REQUIRED IN ADDITION TO THE COMPLETED INITIAL APPLICATION:

1. Picture of applicant
2. Curriculum Vitae
3. Medicare/Medicaid Attestation
4. Statement of Continuing Education
5. Confidentiality Statement
6. TB Questionnaire
7. Statement of Applicant
8. Physician Orientation Statement
9. Consent For Authorizations and Release
10. Copy of all state license
11. Copy of DEA
12. Copy of CDC
13. Insurance Face Sheet
14. ACLS/CPR Certificate, if applicable

MEDICARE NOTICE TO PHYSICIANS

“Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment may be subject to fine, imprisonment, or civil penalty under applicable Federal laws”

Signature

Printed Name

Date Signed

MEDICAID NOTICE TO PHYSICIANS

“Medicaid payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment may be subject to fine, imprisonment, or civil penalty under applicable Federal laws”

Signature

Printed Name

Date Signed

**** Your signature will be kept in medical records, please sign as you would in a medical record chart or medical record electronic record.**

PHYSICIAN ORIENTATION

ONLINE PRESENTATION

To review the following policies go to www.tsjh.org and click on Physician Access

- 1. TSJH Emergency Response Plan**
- 2. HIPAA Training**
- 3. Medical Staff By-Laws**
- 4. Code of Conduct**

My signature below indicates that I have read the policies listed above and agree to abide by the policies of Texas Spine & Joint Hospital.

Signature

Printed name

Date

STATEMENT OF APPLICANT

Please read carefully before signing

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary revocation of privileges. All information submitted by me in the application is true to my best knowledge and belief.

In making this application, I signify my willingness to appear for interview, authorize the Hospital and the medical staff to consult with hospitals or employers with which I have been associated, as well as other persons or entities who may have information concerning my competence, character and ethical qualifications. I consent to the examination of all records that may be pertinent to the evaluation of my professional, moral and ethical qualifications and competence to carry out the clinical privileges I request. I release from any liability all representatives of the Hospital and its medical staff for their acts performed in good faith in connection with evaluation of my application and my credentials. I release from any liability all individuals and organizations who provide information to the Hospital in good faith concerning my competence, ethics, character and other qualifications pertaining to this application, including otherwise privileged or confidential information.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualification.

If approved by the Hospital and the medical staff, I agree to the following:

- 1. To engage in the practice of medicine as defined by the Medical Practice Act, State Board of Licensure, State Board of Governors, Podiatric Licensing Board, or Dental Board of Licensure.**
- 2. Adhere to the policies and procedures of the medical staff and the Hospital as they may apply to my actions of duties.**
- 3. When in the Hospital to wear proper identification indicating my name and title.**
- 4. To always maintain malpractice insurance coverage that meets or exceed the required amount as established by the facility Board of Manager**

**Texas Spine and Joint Hospital
TB Questionnaire**

1. Have you been treated in the past for TB? Yes___No___
2. Have you ever had a positive TB Skin Test? Yes___No___
3. Do you have any of the following symptoms?
- a. Chronic cough? Yes___No___
 - b. Sputum production? Yes___No___
 - c. Night sweats? Yes___No___
 - d. Fever? Yes___No___
 - e. Involuntary weight loss? Yes___No___
 - f. Chronic fatigue Yes___No___

If yes to any above, please explain:

4. Physician review to positive answers:

5. Have you ever completed the Hepatitis B Series Yes___No___

6. Do you any history of natural rubber/latex allergy: Yes___No___

Date of last physical exam: ___/___/___

Examining Physician: _____

Physician Address: _____

Signature of Applicant: _____ Date: _____