

Provider-Agent Confidentiality Agreement

As an Agent or designated Representative of a participating provider in T.I.O.P.A., Inc., a Texas Medical Practice Act § 5.01(a) corporation ("T.I.O.P.A."), I or my agency may be involved in reviewing contracts, reimbursements, billing, administrative, quality or utilization management information, which may include the review of confidential files, reports and other information created by contracted Managed Care Organizations or other providers. I recognize that the confidentiality of such information is vital and I acknowledge and accept that I have an obligation to maintain the confidentiality of all information that I review.

I understand and acknowledge that discussion or disclosure of contractual terms and/or reimbursement detail is contractually forbidden by the majority of the Managed Care Organizations. Discussions or disclosure of said contractual or reimbursement information may only occur with my staff who are in a "need-to-know" position, my client's contracted billing service or other T.I.O.P.A. providers who also participate in the same agreement/s. Contractual or reimbursement information may not be shared with providers, organizations or agents who are not T.I.O.P.A., Inc. participating providers or any other outside sources for comparative or other reasons.

Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with my activities, in the conduct of administrative, and/or medical/professional staff activities, as well as utilization, review, credentialing and contracting committees and activities. I acknowledge the same confidential nature of information, whether access is by computer, medical records, credentialing files, Quality Assurance/Quality Management, interview, meeting, hearing, conversation, or any other means. I acknowledge my responsibility to abide by relevant provisions of the bylaws of the T.I.O.P.A. governing body and/or medical/professional staff, contractual limitations, as well as applicable organization policies and procedures, concerning the confidentiality of information.

Furthermore, my participation in these performance improvement and review activities, and in the improvement of care and services provided by the organization is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every member of the governing body, medical/professional staff, administration, and by every other individual involved.

I realize that if I breach this agreement, T.I.O.P.A. may terminate my relationship with T.I.O.P.A. or take other disciplinary action, and may seek civil penalties against me.

NAME OF TIOPA MEMBER: _____

AGREED AND ACCEPTED:

Signed: _____ Dated: _____

Printed Name: _____

Address: _____

Street

City

State

Zip