St David's Heart & Vascular

Patient Registration Form

Last Name: _____ First: _____ MI: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Choose not to disclose

Date of Birth:_____ Social Security:_ _____

Mailing Address: _____ Apt. #:_____

City:_____ State:_____ Zip:_____

Please check the preferred primary phone number:

☐Home Phone: ( )-_____ ☐Home Work: ( )-_____

☐Mobile Phone: ( )-_____ Email: _____

Preferred Language:_____ Marital Status:_____ Race/Ethnicity:_____

Emergency Contact Person:_____ Relationship: _____

Primary Number: (_____)-_____ Secondary Number: (_____)- _____

Primary Care Physician:_____ Referring Physician: _____

Employer's Name:_____ Occupation:_____

Employer's Mailing Address:_____Suite #: _____

City:_____ State:_____ Zip:_____

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: _____ /_____ /_____

Secondary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: _____ /_____ /_____

Tertiary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: _____ /_____ /_____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to St. David's Heart & Vascular, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

*****Financial acknowledgement for Private Pay Patients or Patients without Insurance*****

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**

St David's Heart & Vascular

PATIENT CONSENT FORM

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a St. David's Heart and Vascular physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at St. David's Heart & Vascular, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witnessing Employee	**Employee Job Title**
Signature of Witnessing Employee	**Date**

Patient HIPAA Acknowledgment and Consent Form

St. David's Heart & Vascular			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ (**Patient/Representative initials**) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient HIPAA Acknowledgment and Consent Form

St. David's Heart & Vascular			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

St David's Heart & Vascular

MEDICAL HISTORY QUESTIONNAIRE

IF IT HAS BEEN THREE OR MORE YEARS SINCE YOUR LAST VISIT, COMPLETE THE ENTIRE FORM
IF LESS THAN THREE YEARS, PLEASE UPDATE AREAS THAT HAVE CHANGED SINCE THE LAST VISIT

Patient Name_____Appt. Date_____ Date of Birth_____ Age_____

Primary Care Doctor_____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? ◯ **YES** ◯ **NO**
HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION ◯ **YES** ◯ **NO** **DATE**_____
HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION ◯ **YES** ◯ **NO** **DATE**_____

Please check anything you have been diagnosed with:

PAST MEDICAL HISTORY

- ○ Aortic aneurysm
- ○ A-Fib
- ○ Anemia
- ○ Angina
- ○ Arrhythmia
- ○ Asthma
- ○ Cancer
- ○ Cardiomyopathy
- ○ Carotid disease
- ○ Clotting disorder
- ○ Coronary artery disease
- ○ Diabetes
- ○ Heart attack
- ○ Heart Failure
- ○ Heart murmur
- ○ High cholesterol
- ○ High blood pressure
- ○ Kidney disease
- ○ Peripheral arterial disease
- ○ Sleep apnea
- ○ Stroke/TIA
- ○ Syncope (fainting)
- ○ Thyroid disease
- ○ Varicose/Spider Veins

OTHER MEDICAL HISTORY

- ○ Anxiety
- ○ Arthritis
- ○ Blood clots in veins/lungs
- ○ COPD/Emphysema
- ○ Depression
- ○ Easy bruising/bleeding
- ○ HIV/AIDS
- ○ Liver problems/Hepatitis
- ○ Menopause
- ○ _____
- ○ Phlebitis/Swelling
- ○ Rheumatic fever
- ○ Stomach/Intestinal ulcers
- ○ Tuberculosis
- ○ _____

PAST CARDIAC SURGERIES

- ○ AAA repair
- ○ Cardiac ablation
- ○ ASD repair
- ○ Coronary bypass
- ○ Cardiac catheterization
- ○ Carotid disease
- ○ Heart Failure
- ○ Cardioversion
- ○ Carotid stent
- ○ Coronary stent
- ○ ICD
- ○ _____
- ○ Kidney disease
- ○ Heart attack
- ○ LARIAT
- ○ Pacemaker
- ○ Peripheral stent
- ○ Valve repair/replacement
- ○ _____

OTHER SURGICAL HISTORY

- ○ Appendectomy
- ○ Carpal tunnel release
- ○ Cataract
- ○ C-section
- ○ _____
- ○ Fracture repair
- ○ Gall bladder
- ○ Hip replacement
- ○ Hysterectomy
- ○ _____
- ○ Knee replacement
- ○ Knee surgery
- ○ Tonsils/Adenoids
- ○ Vasectomy/Tubal ligation
- ○ _____

FAMILY HISTORY

Relationship	*Alive/Deceased*	*Arrhythmia*	*Coronary artery disease*	*Clotting disorder*	*Diabetes*	*Heart attack*	*Heart disease*	*Heart failure*	*High cholesterol*	*High blood pressure*	*Stroke/TIA*	*Sudden cardiac death*	*Varicose veins*	*Venous insufficiency*
Mother														
Father														
Sister														
Brother														
Mat Aunt														
Mat Uncle														
Pat Aunt														
Pat Uncle														
MGM														
MGF														
PGM														
PGF														

○ Adopted ○ Family History Unknown

SOCIAL HISTORY

Do you drink alcoholic beverages? ◯ Yes ◯ No

How many drinks per week? ____ glasses of wine
____ cans of beer
____ shots of liquor
____ mixed drinks

Do you use illegal drugs/abuse prescription drugs? ◯ Yes ◯ No If yes which drugs? _____
How often? _____

Have you ever been a smoker? ◯ Never ◯ Former, quit date _____ ◯ Current smoker
Years smoked _____ Packs per day _____

Do you use smokeless tobacco? ◯ Never ◯ Former, quit date _____ ◯ Current user
Years used _____ Uses per day _____

If you smoke/use tobacco, are you ready to quit? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you drink caffeine? ◯ Yes ◯ No

ALLERGIES

Have you had a reaction to X-Ray contrast dye? ◯ Yes ◯ No

Are you allergic to iodine or shellfish? ◯ Yes ◯ No

Are you allergic to any medications? ◯ Yes ◯ No

If yes, please list medication names_____

St David's Heart & Vascular

Medication List

Patient Name:_____ Date of Birth:_____

Pharmacy:_____ Address/Location:_____ Phone number:_____

Please include all prescription and over-the-counter medications, including herbal products and vitamins.
Please update the form before every physician visit and bring the form to every visit.

	Medication	Dose	How Often
example	*Metoprolol tartrate*	*25 mg*	*Twice daily*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

PLEASE COMPLETE THE PATIENT PORTION ONLY AND SIGN.

Section A: This section must be completed for all Authorizations

Patient Name:	**Recipient's Name:**
Patient's Phone:	**Recipient Address:**
Date of Birth:	**City:** **State:** **Zip:**
Last 4 digit SSN (optional)	**Recipient's Phone:**
Request Dates of Service:	**Email (for releases to email):**
Facility Name(s) and Addresses:	**Purpose of disclosure: ☐ At the request of the individual; or ☐ Other 3rd party recipient (please specify purpose):**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available** ☐ **Encrypted Email** ☐ **Unencrypted Email** There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email. **Note:** In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).

This authorization will expire after 180 days or on the following (please choose only one):
Expiration Date: **Expiration Event:**

Is this request for psychotherapy notes? ☐ No, then you may check as many items below as you need.
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

Description of information to be used or disclosed

☐ **All Pertinent Records** includes those listed below

- ☐ Consultation
- ☐ Discharge Summary
- ☐ ER Report
- ☐ EKG Report
- ☐ History and Physical
- ☐ Clinical / Laboratory Report
- ☐ Medication List
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Problem List
- ☐ Radiology Report

Other Records:

- ☐ Discharge Instructions
- ☐ Labor and Delivery Record
- ☐ Specialty Test / Therapy
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Other

For USCDI Release Requests: to include all elements as defined in the United States Core Data for Interoperability.
Requires Direct Address or National Provider Identifier:

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. Specify any information you want to exclude:

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the Provider receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

IMPORTANT: PLEASE SIGN & DATE THIS FORM

St. David's Heart & Vascular dba Texas Cardiac Arrhythmia

PATIENT NAME_____DATE OF BIRTH_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** any insurance or other third-party benefits available for health care services provided to me. I understand **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Guardian_____
Guarantor
Healthcare Power of Attorney Legal
Other (please specify)_____

Financial and Insurance Policy

Thank you for choosing *St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia* for your healthcare services.

Insurance coverage is considered by *St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia* as an agreement between the patient, the insurance company and the employer, where applicable. St. David's Cardiology d.b.a. Texas Cardiac Arrhythmia is not a party to that agreement and as a result is not bound by any of the covenants, limitations, or restrictions of that policy.

As a service to our patients, we will file insurance claims for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does not release the patient from responsibility of incurred charges for services which have been provided.

All fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made in advance.

If you have health insurance, you are responsible to:

- Verify with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- Obtain any authorizations or referrals required by your insurance carrier.
- Pay our office for any deductible, co-payment or non-covered charges.

Unless specific arrangements have been made in advance for an extension of time, charges for services not covered by insurance are due upon receipt of a patient statement. Patients without sufficient financial resources to pay may be eligible for Patient Assistance. If you have special needs, contact the billing office at 512 206-4300 option 1 for assistance.

If you do not have health insurance coverage:

- Payment for the office visit and all diagnostic services is expected prior to service provided.
- You will receive an estimate of proposed surgical charges and will be expected to contact our business office and speak with our Financial Specialists to make suitable financial arrangements prior to your procedure.
- If you were treated by one of our physicians under emergency circumstances, please contact our Financial Specialists to discuss your financial arrangements as soon as possible. .

Patients without health insurance are eligible for a 35% discount off the standard fee when paid in full at time of service.

Finance plans are available to assist patients with deductibles, co-insurance, and non-covered services. These plans offer flexible financing options to include no interest financing, low minimum monthly payment options and an instant approval process for qualified applicants. For additional information on financing options, contact the billing office at 512 206-4300 option 1.

Statements showing the status of your account are mailed monthly. *St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia* is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact the billing office at 512 206-4300 option 1.

Accounts not paid within 45 days of statement receipt are subject to placement with an outside collection agency.

In the event we receive a returned check, a fee of $35.00 will be charged to your account and payment in full due upon receipt of your statement.

Please acknowledge your understanding and acceptance of *St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia* Financial and Insurance Policy by signing below.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Printed Name Birth Date

St David's Heart & Vascular

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main facility number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Fundraising: We may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g*., good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research:
The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.

- We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICIAL

Telephone Number: (512) 206-4300 Director of Finance
7800 Shoal Creek Blvd. Suite 205N Austin, Texas 78757