PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____
BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX MM DD YY DATE OF BIRTH AGE MARITAL STATUS

Address: _____ _____ ___ _____ (_____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (_____)_____ Day Phone: (_____)_____ Email: _____

Race_____ Language_____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name or School: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Address: _____ _____ _____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (_____) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX MM DD YY DATE OF BIRTH AGE MARITAL STATUS

Address: _____ _____ ___ _____ (_____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name or School: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Address: _____ _____ _____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (_____) _____ (_____)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (_____) _____(_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (_____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ _____/_____/_____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (_____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ____ _____/_____/_____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

EIGHTH AVENUE
OBSTETRICS
&
GYNECOLOGY

LAURA BRADFORD, MD CYNTHIA ROBBINS, MD PATTY HARDT, MD RUTH WILEY, DO HEATHER NEVILLE, MD

NOTICE AND CONSENT FOR THE FOLLOWING TESTS

The American College of Obstetrics and Gynecology recommends that all pregnant patients be offered the following tests. Please initial and circle accept or decline for each option below:

_____accept/deline **Obstetrical ultrasound** is a relatively safe method that uses sound waves to obtain pictures to:

- estimate fetal size, maturity and anatomy
- evaluate placental position and location
- discover singleton versus multiple pregnancy(ies)

It is reasonably accurate method for diagnosis (not treatment) that may aid in the management of your pregnancy. Please be advised that like all tests, we cannot guarantee 100% accuracy. It is possible that a defect or problem is falsely reported or not detected at all.

_____accept/deline **Carrier Screen** (for Hemoglobinopathies, Cystic Fibrosis, Fragile X, and Spinal Muscular Atrophy) is offered to all pregnant women. These diseases are inherited. A positive screen means you are a carrier of a disease, and the father of the baby will need the same screening. If the father is not screened and the mother is a known carrier, the theoretical risk of a child born with cystic fibrosis is 1 in 120.

_____accept/deline **Non-Invasive Prenatal Testing** is a highly sensitive test done by drawing a mother's blood to test a fetus for Down's Syndrome (trisomy 21), Patau Syndrome (trisomy 13) and Edwards' Syndrome (trisomy 18). It can drawn as early as 10 weeks.

_____accept/deline **Sequential Screen/Nuchal Translucency** is a sensitive test done by performing ultrasound of a fetus as well as drawing a mother's blood to test a fetus for Down's Syndrome (trisomy 21), Patau Syndrome (trisomy 13) and Edwards' Syndrome (trisomy 18) as well as open neural tube defects such as spina bifida.

_____accept/deline **Blood transfusion** may be necessary during the course of your pregnancy or as a life saving measure. Occasionally, hemorrhage may complicate pregnancy, endangering both mother and fetus. Knowing there is no adequate substitute for blood, transfusion may be necessary to prevent permanent injury or death. Please be advised that risk for HIV transmission is 1/600,000 and hepatitis 1/60/000. When blood transfusion is considered (as a last resort), risk for severe complications without transfusion will be much higher that these risks.

I understand that I may be responsible for payment of any or all of these tests and could owe money to any or all of the following: my insurance company, laboratory companies, and ultrasound companies.

_____ _____

Patient Name Patient Signature

_____ _____

Witness Date

EIGHTH AVENUE
OBSTETRICS & GYNECOLOGY

NAME:_____ DOB:_____

OCCUPATION/EMPLOYER: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWES SEPERATED

REFERRED BY: _____

PCP_____ PHARMACY_____

PAST MEDICAL HISTORY

ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

GYNECOLOGIC HISTORY

AGE OF FIRST PERIOD _____

DATE OF LAST MENSTRUAL PERIOD _____

NUMBER OF DAYS YOU BLEED _____

NUMBER OF DAYS BETWEEN PERIODS _____

ABNORMAL PAPSMEAR ____YES ___NO DATES_____

BIRTH CONTROL METHOD:

_____PILLS ____CONDOMS ____TUBAL LIGATION ____NONE

_____DEPO-PROVERA ____DIAPHRAGM ____VASECTOMY

_____IUD ____NATURAL FAMILY PLANNING ____WITHDRAW

OBSTETRIC HISTORY

TOTAL NUMBER OF PREGNANCIES _____ NUMBER OF BIRTHS _____

NUMBER OF MISCARRIAGES _____ NUMBER OF LIVING CHILDREN _____

MO/YR	TYPE OF DELIVERY	SEX	BIRTHWEIGHT	NAME	COMPLICATIONS
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

TODAYS DATE: _____

SEE OTHER SIDE

HOSPITALIZATIONS: Please list any hospitalizations or surgeries excluding childbirth.

YEAR	REASON FOR HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HABITS: Please check habits you have.

_____SMOKING. Number of packs per day_____

_____ALCOHOL. Number of drinks per week_____

_____STREET DRUGS. Describe_____

_____EXERCISE. Describe_____

PAST MEDICAL HISTORY AND FAMILY HISTORY

ILLNESS	PERSONAL	FAMILY
1. HEART DISEASE	_____	_____
2. HYPERTENSION	_____	_____
3. RESPIRATORY DISEASE	_____	_____
4. BREAST DISEASE/CANCER	_____	_____
5. JAUNDICE/HEPATITIS	_____	_____
6. GALL BLADDER DISEASE	_____	_____
7. HIATAL HERNIA/PEPTIC ULCER	_____	_____
8. BOWEL DISORDERS	_____	_____
9. KIDNEY DISEASE	_____	_____
10. URINARY INFECTIONS	_____	_____
11. URINARY INCONTINENCE	_____	_____
12. ANEMIA	_____	_____
13. BLOOD DISEASE	_____	_____
14. BLOOD TRANSFUSIONS	_____	_____
15. PHLEBITIS	_____	_____
16. THYROID DISEASE	_____	_____
17. DIABETES	_____	_____
18. CANCER	_____	_____
19. EPILEPSY/SEIZURES	_____	_____
20. NEUROLOGIC DISEASES	_____	_____
21. SKIN DISEASE/CANCER	_____	_____
22. TUBERCULOSIS	_____	_____
23. SEXUALLY TRANSMITTED DISEASE		
GONORRHEA	_____	_____
CHLAMYDIA	_____	_____
SYPHILIS	_____	_____
HERPES	_____	_____
HIV	_____	_____
HPV/CONDYLOMA/WARTS	_____	_____

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES PATIENT THE RIGHT TO REQUEST ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME. THIS INFORMATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- ❒ HOME TELEPHONE _____
- ❒ O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- ❒ LEAVE NAME/DOCTOR WITH CALL BACK NUMBER ONLY
- ❒ WORK TELEPHONE _____
- ❒ LEAVE DETAILED MESSAGE ON WORK VOICE MAIL
- ❒ LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK NUMBER ONLY
- ❒ WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
- ❒ OTHER _____

_____

PATIENT SIGNATURE DATE

_____

PRINT NAME BIRTHDATE

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED WILL BE DOCUMENTED ON THE TEST RESULT, PROGRESS NOTE OR PATIENT COMMUNICATION IN QUESTION.

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

Treatment, Payment, Health Care Operations

We are permitted to use and disclose your medical information to those involved in your treatment. Privia Medical Group North Texas (Privia) (f/k/a Texas Health Care, PLLC) is a multi-specialty practice and when we provide treatment, we may request that all of your physicians share your medical information with us. For example, your care may require both primary care physicians and specialty care physicians. When we provide treatment, we may request information from all of your physicians so that we can appropriately treat you for all other medical conditions, if any.

- If your physician is a primary care physician, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

- If your physician is a specialist, when we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

- If your treatment has been ordered by your physician, but is being provided by an ancillary department, such as any therapies, we are permitted to use and disclose your medical information to those involved in your treatment. When we provide treatment, we may request that your physician share your medical information with us. Also, we may provide your physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;

- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Other uses and Disclosures

We will not use or sell your protected health information for marketing or any other purposes without your expressed permission.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations.

- If you have health insurance coverage and personally pay, out-of-pocket, in full for medical services provided, you may request that we not submit any information regarding these services to your insurance carrier.
- To request this restriction, notify the front desk of the physician's office. You will be provided with a separate form documenting this request. Please give or send the request to the Practice Team Liaison in this office.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Emailing or Downloading PHI

If you email us medical or billing information from a private email address (such as a Yahoo, Gmail, etc. account), your information will not be encrypted unless you use a secure messaging portal to send it to us. If you request us to post your information in drop-boxes, on flash drives, CDs, etc., your information may not be secure. Privia is not responsible for the privacy or security of your PHI if you request that we send it to you in an unsecured manner or download or post it on a drop-box, flash drive, CD or other unsecure medium. In addition, Privia is not responsible if your PHI is redisclosed, damaged, altered or otherwise misused by an authorized recipient. In addition, if you share an email account with another person (for example, your spouse/partner/roommate) or choose to store, print, email, or post your PHI, it may not be private or secure.

Business Associates

Your PHI may be disclosed to individuals or entities who provide services to or on behalf of Privia. Pursuant to HIPAA, Privia requires these companies sign business associate or confidentiality agreements before we disclose your PHI to them. However, Privia generally does not control the business, privacy, or security operations of our business associates.

Incidental Disclosures

Despite our efforts to protect your privacy, your PHI may be overheard or seen by people not involved in your care. For example, other individuals at your provider's office could overhear a conversation about you or see you getting treatment. Such incidental disclosures are not a violation of HIPAA.

Consent to Disclose Sensitive Health and Substance Use Disorder Information

During the registration process, you consent to the release of federally assisted substance use disorder information, information regarding treatment of communicable diseases and mental health information. If you do not wish for this information to be disclosed, you must notify us in writing.

Sensitive Health Information

Federal and state laws provide special protection for certain types of health information, including psychotherapy notes, information about substance use disorders and treatment, mental health and AIDS/HIV or other communicable diseases, and may limit whether and how we may disclose information about you to others.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and

Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

Secretary of the U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877)696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Jason A. Copling, Privacy Officer
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
jcopling@priviahealth.com

This notice is effective on the following date: June 28, 2017.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. This form confirms that you understand that the services provided are necessary and appropriate and explains your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out.
You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).

- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least twenty-four (24) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!

PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____, with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date #_____

_____ _____

Date *Patient/Legal Representative*

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