Methodist
RICHARDSON BREAST SURGEONS

2805 E. President George Bush Turnpike
Richardson, TX 75082

Phone: (469) 204-6230
Fax: (469) 204-6239

PATIENT

NAME: LAST	FIRST	M.I.	DATE OF BIRTH	AGE

ADDRESS: STREET	APT. #	CITY	ST	ZIP

PHONE: HOME	CELL	WORK

PREFERRED: ☐ HOME ☐ CELL ☐ WORK

SOCIAL SECURITY NUMBER — —	EMERGENCY CONTACT NAME / RELATION	CONTACT PHONE #	SEX ☐ M ☐ F

RACE: ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ CAUCASIAN ☐ HISPANIC OR LATINO ☐ DECLINE TO PROVIDE ☐ OTHER: _____	**ETHNICITY:** ☐ HISPANIC ☐ LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO PROVIDE	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ NOT A STUDENT	EMAIL ADDRESS

PARENT OR GUARANTOR

NAME: LAST	FIRST	M.I.	PHONE

STREET ADDRESS	CITY	ST	ZIP

SOCIAL SECURITY NUMBER — —	RELATION TO PATIENT	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	SEX ☐ M ☐ F

PRIMARY INSURANCE

☐ **CHECK IF SAME AS GUARANTOR** ☐ **SELF PAY**

PRIMARY INSURED PERSON	INSURED STREET ADDRESS	CITY	ST	ZIP

RELATION TO PATIENT	SOCIAL SECURITY NUMBER — —	INSURED DATE OF BIRTH

INSURANCE COMPANY NAME	PHONE NUMBER

POLICY NUMBER	GROUP NUMBER	CLAIM ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

SECONDARY INSURANCE

PRIMARY INSURED PERSON	INSURED STREET ADDRESS	CITY	ST	ZIP

RELATION TO PATIENT	SOCIAL SECURITY NUMBER — —	INSURED DATE OF BIRTH

INSURANCE COMPANY NAME	PHONE NUMBER

POLICY NUMBER	GROUP NUMBER	CLAIM ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

How did you hear about us? _____

Methodist Richardson Breast Surgeons
2805 E. President George Bush Turnpike
Richardson, Texas 75082

Jenevieve Hughes, M.D., FACS

NEW PATIENT INFORMATION FORM *(please be complete)*

Patient: _____ Date: _____

Who Referred You?_____ Who is your Primary Doctor? _____

WHAT IS THE REASON FOR YOUR VISIT? *(please be complete)*

☐ Breast Lump ☐ Nipple Discharge ☐ Second Opinion
☐ Breast Pain ☐ Abnormal Mammogram (MMG) ☐ Concern about your Breast Cancer Risk
☐ Breast Cancer ☐ Other (please elaborate): _____

MEDICAL HISTORY

PATIENT MEDICAL HISTORY

Diabetes	No	Yes	Asthma	No	Yes	High Cholesterol	No	Yes
High Blood Pressure	No	Yes	Heart Disease	No	Yes	Kidney/Liver Disease	No	Yes
Cancer	No	Yes	Thyroid Problems	No	Yes	Emphysema/Lung Disease	No	Yes
Arthritis	No	Yes	Blood Clots	No	Yes	Stroke	No	Yes
Mitral Valve Prolapse	No	Yes	Osteoporosis	No	Yes	Depression/Anxiety	No	Yes

Other Medical Problems: _____

Previous Surgeries or Operations: _____ When: _____

_____ _____

_____ _____

_____ _____

PATIENT SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
Use of Alcohol: ☐ Never ☐ Rarely ☐ Socially ☐ Daily
Use of Tobacco: ☐ Never ☐ Previously but Quit ☐ Daily _____Packs per Day
Caffeine: ☐ Rarely ☐ Occasionally ☐ Daily _____Cups per Day
Recreational Drug Use: ☐ Yes ☐ No
Exercise: ☐ Yes ☐ No If Yes, what type and how often? _____
Work/Employment: ☐ Yes ☐ No If Yes, what is your occupation? _____

MEDICATION (INCLUDE HERBAL MEDICATIONS, VITAMINS AND OVER-THE-COUNTER)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you take Aspirin? ☐ Yes ☐ No

ALLERGIES:

Do you have any allergies or adverse reactions to medication? ..... ☐ Yes ☐ No
If so, which medication(s)? _____
Are you allergic to any foods?..... ☐ Yes ☐ No
If so, which food(s)? _____
Are you allergic to latex?..... ☐ Yes ☐ No
Are you allergic to adhesives?..... ☐ Yes ☐ No
Are you allergic to IV contrast/dye?..... ☐ Yes ☐ No

FAMILY HISTORY

☐ Cancer..... Who? _____ What type? _____

Who? _____ What type? _____

Who? _____ What type? _____

Who? _____ What type? _____

What is your race/ethnic background: _____

Is your family of Jewish descent? ..... No Yes

Are you currently suffering from or have you any prior history of:

CONSTITUTIONAL SYMPTOMS

Good General Health Lately..... No Yes
Recent Weight Change..... No Yes
Fever ..... No Yes
Fatigue..... No Yes

EYES

Eye Disease or Injury ..... No Yes
Blurred or Double Vision..... No Yes
Glaucoma ..... No Yes

EARS, NOSE, MOUTH AND THROAT

Hearing Loss or Ringing..... No Yes
Chronic Sinus Problem or Rhinitis..... No Yes
Nose Bleeds ..... No Yes
Mouth Sores..... No Yes
Sore Throat or Voice Change..... No Yes

CARDIOVASCULAR

Chest Pain or Angina Pectoris ..... No Yes
Palpitation ..... No Yes
Shortness of Breath with Walking or Lying Flat..... No Yes
Swelling of Feet, Ankles or Hands..... No Yes

RESPIRATORY

Chronic or Frequent Coughs..... No Yes
Spitting Up Blood..... No Yes
Shortness of Breath..... No Yes
Asthma or Wheezing ..... No Yes

GASTROINTESTINAL

Loss of Appetite..... No Yes
Change in Bowel Movement ..... No Yes
Nausea or Vomiting ..... No Yes
Frequent Diarrhea ..... No Yes
Painful Bowel Movements or Constipation ..... No Yes
Rectal Bleeding or Blood in Stool..... No Yes
Abdominal Pain or Heartburn..... No Yes
Peptic Ulcer (Stomach or Duodenal)..... No Yes

GENITOURINARY

Frequent Urination..... No Yes
Burning or Painful Urination..... No Yes
Blood in Urine ..... No Yes
Incontinence or Dribbling..... No Yes
Kidney Stones ..... No Yes

MUSCULOSKELETAL

Joint Pain, Stiffness, or Swelling..... No Yes
Weakness of Muscles or Joints..... No Yes
Muscle Pain or Cramps..... No Yes
Back Pain ..... No Yes
Difficulty Walking ..... No Yes

INTEGUMENTARY

Rash or Itching..... No Yes
Change in Skin Color ..... No Yes
Change in Hair or Nails..... No Yes

NEUROLOGICAL

Frequent or Recurring Headaches ..... No Yes
Light Headed or Dizzy ..... No Yes
Seizures..... No Yes
Tremors ..... No Yes
Memory Loss or Confusion..... No Yes
Insomnia..... No Yes

ENDOCRINE

Excessive Thirst or Urination ..... No Yes
Heat or Cold Intolerance..... No Yes
Skin Becoming Dryer ..... No Yes

HEMATOLOGIC / LYMPHATIC

Slow to Heal After Cuts..... No Yes
Bleeding or Bruising Tendency ..... No Yes
Anemia..... No Yes
Phlebitis..... No Yes
Past Transfusions ..... No Yes
Enlarged Glands..... No Yes

GYNECOLOGICAL

Number of Pregnancies:____ Number of Miscarriages:____
Age at First Period:_____
Age at Delivery of Your First Child:_____
Did you breast feed?..... No Yes
Have you gone through menopause?..... No Yes
If yes, at what age?_____
If no, when was your last menstrual period?_____

Have you had a hysterectomy?..... No Yes
Have your ovaries been removed? ..... No Yes
Have you ever taken birth control pills? ..... No Yes
How many years?_____ When did you stop?_____
Have you ever taken estrogen?..... No Yes
How many years?_____ When did you stop?_____
Bra size: _____
Have you had any prior breast biopsies?..... No Yes

FOR OFFICE USE ONLY

Date:_____ Reviewed By:_____

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Jenevieve Hughes, MD
Breast Surgeon

Patient Name: _____ Date: _____

In connection with the medical services which I am receiving from Dr. Hughes, I do hereby consent for Jenevieve Hughes, M.D., or a qualified Photographer approved by Dr. Hughes, to take photographs of me that will be used in my medical record for purposes of medical treatment and/or procedures. Such Photographs shall remain the property of Medhealth.

I understand that the use of my photographs is for medical purposes **ONLY** and that they will become a part of my permanent medical records:

I may withdraw this consent at any time, and such withdrawal will not in any way affect me. I understand a withdrawal of consent must be made in writing, and that withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I HEREBY FULLY AND EXPRESSLY RELEASE, INDEMNIFY AND HOLD HARMLESS RICHARDSON PHYSICIAN ALLIANCE, ANY PARENT AND OR ENTITY THEREOF, THEIR DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, REPRESENTATIVES, SUCCESSORS, ASSIGNS AND SUBCONTRACTORS FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION THAT I MAY HAVE, OF ANY NATURE WHATSOEVER, WHICH MAY IN ANY MANNER RESULT FROM THE USE OF THE PHOTOS.

I HAVE FULLY READ THE FOREGOING "CONSENT FORM." I FULLY UNDERSTAND ITS CONTENTS AND ACCEPT AND AGREE TO THE ABOVE IN ITS ENTIRETY. I AM SIGNING THIS CONSENT VOLUNTARILY AND ON MY OWN FREE WILL.

PATIENT*

*Signed:*_____ *Date:* _____

Printed name: _____

If the patient is a minor or is unable to consent in writing for any reason, consent must be obtained on the patient's behalf by a parent or legal guardian.

Parent/Guardian Signature: _____

Relationship: _____

For Office Use Only
Witness: _____ *Date:* _____

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In order to better protect your privacy under HIPAA, we have created this consent form for releasing information to family members and/or other persons of the patient's choosing. This will also be used for consent to leave telephone messages at the selected phone numbers. Many times we have patients whose family members call requesting medical information and legally we are not allowed to release that information without the patient's written consent. Please take a moment to fill out this form, and we will keep it on file in your chart. It will be in effect until such notice is given in writing stating otherwise.

Please Print:

I, _____, date of birth _____ /_____ /_____, hereby give my consent for release of information contained within my medical records. This may include appointment, medical diagnosis and/or treatment to the following person(s):

Name: _____ Relationship: _____ Email Address: _____

Name: _____ Relationship: _____ Email Address: _____

Name: _____ Relationship: _____ Email Address: _____

Name: _____ Relationship: _____ Email Address: _____

Okay to leave messages at the following number(s):

☐ Home (_____) _____–_____ ☐ Work (_____) _____–_____

☐ Cell (_____) _____–_____ ☐ Other (_____) _____–_____

Results and/or other correspondence from my physician's office can be mailed to:

☐ Home: ☐ Yes ☐ No

☐ Email: ☐ Yes ☐ No

If yes, provide email address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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1. **Authorization to Release Information:**
I authorize MEDHEALTH to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payor for the purpose of obtaining payment on account of (1) **MEDHEALTH,** (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. **Assignment of Benefits:**
Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for the costs of collection.

I understand that I am responsible for providing **MEDHEALTH** all insurance information at the time of registration to allow for verification of benefits and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to MEDHEALTH. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

3. **Medicare/Medicaid Assignment of Benefits:** *(If you do not have either of these insurance plans please proceed to signature line.)*

   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

   Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

   Initial _____

_____
Patient Printed Name

_____ _____
Patient Signature (or Guarantor if patient is a minor) Date

_____ ☐ Patient under 18 years of age
Witness

_____ _____
Translator Printed Name Translator Signature

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Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Primary phone: _____ Secondary phone: _____

Social Security Number: _____ Physician Seen: _____

Release Records From:

_____
Name

_____
Address

_____
City *State* *Zip Code*

_____
Phone *Fax*

Release Records To:

_____
Name

_____
Address

_____
City *State* *Zip Code*

_____
Phone *Fax*

Purpose: □ Continued Care □ Legal/Attorney □ Disability □ Other: _____

Please send a copy of my records as indicated for the date(s) of treatment: _____

_____

□ Entire Record
□ Laboratory Test Results
□ Discharge Summery
□ X-ray/Imaging Reports
□ Consultation Report
□ ER Records
□ Operative Records
□ Other: _____
□ X-ray films
□ History & Physical
□ Pathology Records

I understand that I may revoke this authorization in writing at any time prior to the release of the information specified above. I hold harmless **Methodist Richardson Breast Surgeons** and/or its representatives from liability resulting in the release/obtaining of the above information. This authorization expires 90 days from the date signed. Pursuant to state and federal law, you are hereby advised that the information that you authorized for release may include: any/all test results, diagnosis and/or treatment for HIV, AIDS, sexually transmitted diseases (i.e. herpes, Chlamydia), psychiatric disorders, mental health, drug and/or alcohol abuse.

_____
Signature of patient *Date*

_____
Witness *Date*

_____
Signature of Responsible Party/Guardian *Date*

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OFFICE POLICY AND PROCEDURES

Office Hours – Monday – Friday 8:00 am – 5:00 pm
Closed for lunch 12:00 pm – 1:00 pm

Registration – All patients must complete a patient information packet before seeing their provider and provide a picture identification card.

Insurance – Insurance cards must be presented prior to each office visit. *Please notify our office if there is a change in your insurance plan or coverage.* We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies. Any dispute for unpaid charges from the insurance company will be billed to the member. ALL PATIENTS MUST HAVE AN INSURANCE CARD IN ORDER TO UTILIZE BENEFITS.

Referrals – Allow 5-7 working days to process routine referrals.

Medication Refills – All prescription refill requests should be called into your pharmacy at least **five (5)** working days before the last pill is taken to allow adequate time for approval. Refills will only be handled during normal business hours Monday through Friday. Narcotic prescriptions (pain medication) will not be refilled after office hours or on weekends.

Appointment/No Show – We request a 24-hour notice for appointment cancellations. Patients with three (3) missed appointments and/or no shows can result in dismissal from this practice. If you no show to your appointment you will be charged $25.00. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled office visit.

Behavior – Physical and/or verbal abuse towards the office staff will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate dismissal from the practice.

After Hours – Our phone message will provide patients with a number to call our answering service for emergencies. The answering service will notify the physician on call. Calls for refills will not be returned.

Charges – Full payment is due at the time services are rendered unless other payment arrangements have been made.

FMLA and Insurance Forms – Any paperwork that must be completed by Methodist Richardson Breast Surgeons will require an additional fee of $50. Fee must be paid in advance before forms can be filled out. Please allow 1 week for these forms to be processed.

NSF/Closed Accounts – There will be a $35.00 charge added for returned checks.

Thank you for understanding and agreeing to our policy. We are glad that you have chosen Methodist Richardson Breast Surgeons as your health care provider.

Signature: _____ **Date:** _____

MedHealth
Notice of Privacy Practices

Effective Date: April 14, 2003

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.

If you have any questions about this Notice please contact: HIPAA Privacy Officer at 214-884-4770.

This Notice describes how physicians engaged in the private practice of medicine at MedHealth facilities (collectively all such physicians are referred to as "Practitioners") may use and disclose your protected health information for purposes of treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. It also describes your rights to access and control your protected health information.

A record of care and services is created in order to manage the care you receive and to comply with certain legal requirements. The Practitioners understand that medical information about you is personal. The Practitioners are committed to protecting medical information about you. The Practitioners are required by law to:

- maintain the privacy of your protected health information;
- provide you with this notice summarizing the Practitioners legal duties and practices related to the use and disclosure of medical information;
- abide by the terms of the notice currently in effect;
- notify affected individuals following a breach of unsecured Protected Health Information.

The Practitioners may dispose of your medical records ten (10) years after the date of your last visit to an MedHealth facility, or after applicable periods specified in existing law.

The Practitioners reserve the right to change this notice. The new notice will be effective for all protected health information that the Practitioners possess at that time and that the Practitioners receive in the future. The current notice will be available upon request at MedHealth facilities.

1. Protected Health Information – Uses and Disclosures

The following categories describe the types of uses and disclosures of your Protected Health care Information that the Practitioners, their office staff, and their agents may make once you have acknowledged receipt of this notice. For each category of uses or disclosure this notice will explain what is meant and provide some examples. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made as allowed under the law.

Treatment, Including Continuity Of Care: The Practitioners will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your Protected Health Information. For example the Practitioners would disclose your protected health information, as necessary, to a home health agency that provides care to you. The Practitioners will also disclose protected health information to other physicians who may be treating you when you have given the necessary permission to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, the Practitioners may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: The Practitioners may use and disclose medical information about you so that the treatment and services you receive or are provided on your behalf by the Practitioners covered by this Notice may be billed to and payment may be collected from you, an insurance company or a third party. For example, the Practitioners may need to give your health plan information about services you received so your health plan will pay the involved Practitioners or reimburse you for the service. The Practitioners may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. You have the right to request that any disclosures to your health plan made for purposes of receiving payment or to otherwise facilitate healthcare operations be restricted where payment for the service or item at issue has been remitted in full by a person or entity other than the health plan.

Healthcare Operations. The Practitioners may use or disclose, as needed, your protected health information in order to support the business activities of their practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, the Practitioners may disclose your protected health information to their office staff to coordinate your care and records. In addition, the Practitioners may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. The Practitioners may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders. The Practitioners may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Treatment Alternatives and Health-Related Benefits and Services. The Practitioner may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact your Practitioner's office from where you received such material to request, in writing, that these materials not be sent to you.

Fundraising Activities. A Practitioner may use or disclose your demographic information and the dates that you received treatment from your Practitioner, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact your Practitioner's office, in writing, and request that these fundraising materials not be sent to you.

Facility Directories: Unless you sign a document to become a "No Information Patient," the Practitioners may use and disclose in a directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

Individuals Involved in Your Care or Payment for Your Care. The Practitioners may release medical information about you to a friend or family member who is involved in your medical care. The Practitioners may also give information to someone who helps pay for your care. The Practitioners may also tell your family or friends your condition and that you are in the hospital. In addition, the Practitioners may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Emergencies. The Practitioners may use or disclose your protected health information in an emergency treatment situation without your acknowledgment of this Notice. If this happens, an attempt will be made to try and obtain your acknowledgement as soon as reasonably practicable after the delivery of treatment. If a Practitioner is required by law to treat you and the Practitioner has attempted to obtain your acknowledgment but is unable to obtain your acknowledgment, he or she may still use or disclose your protected health information for treatment, payment and operation purposes.

Research. The Practitioner may use or disclose information about you for purposes of research projects approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The Practitioner will almost always ask for your specific permission if they will have access to your name, address or other information that reveals who you are, or will be involved in your care.

Food and Drug Administration. The Practitioner may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required

As Required By Law. The Practitioners will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety.. The Practitioners may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor the Practitioners may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Practitioners may release medical information about you as required by military command authorities. The Practitioners may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation The Practitioners may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Participation in Health Information Exchange. The Practitioners, affiliated hospitals, and/or other healthcare professionals that provide treatment services to MedHealth patients may participate in a Health Information Exchange ("HIE"). An HIE allows participating providers secure, immediate electronic access to your pertinent protected health information maintained by participating health care providers as necessary as necessary for treatment. You have the option to "opt-out" of participation in the HIE, precluding your providers from sharing your health information for purposes of treatment. If you have not opted out of the HIE, your protected health information will be available through the HIE to participating health care providers that have a treatment relationship with you, consistent with this Notice of Privacy Practices and the law. If you opt-out of participation in the HIE, your protected health information will not be available through the HIE for your treating providers to search and locate in conjunction with your treatment, but will otherwise continue to be used consistent with this Notice of Privacy Practices and the law. For more information about opting out of the HIE, or for rejoining the HIE subsequent to a previous decision to opt out, you may visit www.ntahp.org, or call (817)-274-6300.

Public Health Risks. The Practitioners may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;

- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Practitioners may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Practitioners may disclose medical information about you in response to a court or administrative order. The Practitioners may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Practitioners may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct in the clinic; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Practitioners may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Practitioners may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Practitioners may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. The Practitioners may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Practitioners may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Uses and Disclosures: Under the law, the Practitioners must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing, except to the extent that a Practitioner or his or her practice has taken an action in reliance on the use or disclosure indicated in the authorization. Examples of the types of uses and disclosures that require a written authorization include: uses or disclosures of psychotherapy notes not subject to specific exceptions defined within applicable regulations; uses and disclosures of Protected Health Information to be used for marketing, unless communication is made face to face or is for a promotional gift of nominal value; uses and disclosures of Protected Information that is a sale of such information as defined within applicable regulations

2. Your Health Information Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to inspect and/or obtain a written or electronic copy of your protected health information. You have the right to inspect and/or obtain a copy of your medical information, as provided by law. Usually this includes medical and billing records but does not include psychotherapy notes. You must submit your request to inspect and/or obtain a copy of your health information in writing to the MFHC facility at which you were treated. Your request to inspect and/or obtain a copy may be denied in certain circumstances and in case of such denial, you may have the right to have this decision reviewed by a health care professional of the Practitioner's choosing. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the MFHC facility at which the Practitioner provided you care.

Right to have your physician amend your protected health information. If you feel medical information the Practitioner have about you is incorrect or incomplete, you may request that the information be amended. You must submit a request for amendment to the MFHC facility at which you were treated with a reason supporting your request to amend. The request may be denied if the request is;

- Not in writing
- not supported or corroborated
- to amend information that is accurate or complete
- to amend parts of the information you are not permitted to inspect or copy, by law
- to amend part of the record which is not maintained or was not created by the Practitioner.

For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the MedHealth facility at which the Practitioner provided you care.

Right to request a restriction of your protected health information. You may ask a Practitioner not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care, unless provided for by law. The Practitioners are not required by law to agree to a restriction that you may request , unless the request is to restrict a disclosure to a health plan for purposes of payment or operations that relates to a service or item for which you or a source other than the health plan has already remitted payment in full. You may request a restriction by completing a Request for Restrictions form and present it to a registration representative at the MedHealth facility at which you were treated for acceptance or denial. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the MedHealth facility at which the Practitioner provided you care.

Right to request confidential communications. You have the right to request that the Practitioner communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that you only be contacted at work or by mail. Please make this request in writing to a registration representative at the MFHC facility at which you were treated. You will not be asked the reason for your request, and reasonable requests will be accommodated. Your request may also be conditioned on you providing information as to how payment will be handled or specification of an alternative address or other method of contact. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to communications of or with the MedHealth facility at which the Practitioner provided you care.

Right to an accounting of disclosures, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or other allowed disclosures including those to family members or friends involved in your care, as described in this Notice of Privacy Practices. It may also exclude disclosures made based upon a written authorization from you. You have the right to a list of disclosures for time periods no longer than six years and not before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists you may be charged a fee which you will be asked for prior to compiling the list. Please make any requests for a list of disclosures covered by this Notice to the MedHealth facility where you were treated, in writing. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to disclosures made by the MedHealth facility at which the Practitioner provided you care.

Right to obtain a paper copy of this notice . Upon request, the Practitioner office will provide you with a paper copy of this notice, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to a Practitioner, to the MedHealth facility were the Practitioner provided you care, or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Practitioner. You may file a complaint with the Practitioner by notifying your Practitioner or with the MedHealth facility by notifying MedHealth, HIPAA Privacy Officer, 3400 W. Wheatland Rd, POB III, Suite 360, Dallas Texas 75237, of your complaint. All complaints must be in writing, and you will not be retaliated against for filing a complaint.

You may contact our Privacy Contact at (214) 884-4770.

This notice was published and becomes effective on February 18, 2013.

Methodist
RICHARDSON BREAST SURGEONS

PATIENT CONSENT FOR DISCLOSURE OF HEALTHCARE INFORMATION FORM

Methodist Richardson Breast Surgeons Notice of Privacy Practices (the "NOTICE") provides information about how Methodist Richardson Breast Surgeons may use and disclose protected health information about you. You have the right to review the Notice before signing this consent. A copy of the current Notice is posted in the waiting room. The Notice contains on the first page, in the top right-hand corner, the effective date. As provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Patient Name	Patient Signature
Print Parent or Legal Guardian Name	Parent or Legal Guardian Signature
Relationship to Patient if Legal Guardian	
Date	Witness Signature