

New Patient Registration and Questionnaire SECTION 1

Patient Information			
Name:		MRN:	
AKA:		Sex: ☐ M ☐ F	
Birth Date:	Marital Status:	Preferred Method of Contact:	
		☐ Email ☐ Mail	
Email Address:		☐ Text ☐ Phone	
Address 1:		Home Phone:	
Address 2:		Mobile:	
City, State:		Zip:	
Guarantor Information (Person Responsible for Bill)			
Guarantor Name:			
Relation to Guarantor: ☐ Parent ☐ Sibling ☐ Child ☐ Aunt/Uncle ☐ Legal Guardian ☐ Other			
Address:		Telephone #:	
City, State:		Zip:	
Patient Employer Information		Guarantor Employer Information	
Employer:		Employer:	
Address 1:		Address 1:	
Address 2:	Telephone #	Address 2:	Telephone #:
City, State:	Zip:	City, State:	Zip:
Emergency Contact Information			
Name:		Relation:	
Address:			
City, State:		Zip:	
Home Telephone #:		Mobile #:	
Insurance Information			
Primary Insurance:	Subscriber Name:		DOB:
	ID Number:		
Secondary Insurance:	Subscriber Name:		DOB:
	ID Number:		
Tertiary Insurance:	Subscriber Name:		DOB:
	ID Number:		

New Patient Registration and Questionnaire SECTION 2

1. Demographic

Race	Ethnicity
☐ White ☐ African American/Black ☐ American Indian ☐ Pacific Islander ☐ Other ☐ Decline ☐ Unknown	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other ☐ Unknown
Do you need a translator? ☐ Y ☐ N	Primary spoken language:
Do you have an Advance Directive? : ☐ Y ☐ N	Are you hearing impaired? ☐ Y ☐ N

2. Health Maintenance

a. When was the last time you had the following tests performed? (please check all that apply)

	Past Year	2 Years	10 years	Never
Colonoscopy				
Routine Physical				
Eye Exam				
Breathing Test				
Bone Density				
Cholesterol Check				
Flu Shot				
Pneumonia Vaccine				
Women's Health				
Mammogram				
PAP Smear				

3. Past Medical History

a. Do you have or have you ever been diagnosed with: (If yes, please specify how long ago)

	Yes	No	0 – 12 months	1 – 3 years	3 - 5 years	5 – 10 years	10+ years
Diabetes							
High Blood Pressure							
Heart Disease							
High Cholesterol							
Cancer							
Stroke							
Seizures							
Lung Disease (Asthma, COPD, etc.)							
Glaucoma							
HIV							
Other(s):							

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b. Have you been hospitalized in the past year? ☐ Y ☐ N (If yes, please specify below)

Date	Hospital	Reason

For additional space, please use page 5 addendum 3b

c. Do you see any specialists? ☐ Y ☐ N If yes, please provide the name and reason:

Specialist Name	Reason

For additional space, please use page 5 addendum 3c

4. Past Surgical History

Have you ever had surgery? ☐ Y ☐ N If Yes, please explain:

Date	Procedure	Reason

For additional space, please use page 5 addendum 4

5. Family History

	Yes	No	Relation (e.g. father)
Diabetes			
High Blood Pressure (Hypertension)			
Heart Disease			
High Cholesterol			
Cancer			
Stroke			
Seizures			
Lung Disease (Asthma, COPD, etc.)			
Other(s):			

6. Social History

a. What is your smoking status? Never _____ Past Smoker _____ Current Smoker _____

How many packs per day? _____ How many years of smoking history? _____

b. Do you drink alcoholic beverages? ☐ Y ☐ N If yes, approx. # drinks per week: _____

c. Have you or do you use any drugs for recreational use (confidential): ☐ Y ☐ N

If yes, please explain: _____

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d. Have you been exposed to any conditions/events that could potentially be damaging to your health (i.e. military combat, occupational hazards, etc.)? If yes, please explain: _____

7. Allergies

Do you have any food or drug allergies? ☐ Y ☐ N If yes, please list and describe:

Food or Drug	Reaction

For additional space, please use page 5 addendum 7

8. Medications

Please list all medications, including over the counter "OTC" medications and herbal supplements that you are currently taking or have taken in the last 12 months:

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

For additional space, please use page 5 addendum 8

9. Pharmacy Information

Please provide us with the name and location of your preferred pharmacy:

Name: _____ Phone: _____

Location: _____

10. Patient/Provider Review

Please sign below to confirm that the information above is accurate and has been reviewed.

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____

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Addendum

3.b Past Hospitalizations

Date	Hospital	Reason

3.c Current Specialists

Specialist Name	Reason

4. Past Surgical History

Date	Procedure	Reason

7. Allergies

Food or Drug	Reaction

8. Medications

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

DIGNITY PRIMARY CARE

ADULT PATIENT CONSENT FORM

Thank you for allowing Dignity Primary Care to serve you. Please complete this consent form and provide proper documentation of insurance in order to receive services.

CONSENT FOR TREATMENT

I hereby give my consent to receive comprehensive health services at Dignity Primary Care. I further authorize any health professional working for Dignity Primary Care to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Dignity Primary Care personnel under the instructions, orders or direction of such physician(s).

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of all of my insurance benefits, sick benefits, Medicare benefits and injury benefits due because of liability of a third-party, payable by any party or organization directly to Dignity Primary Care or any Dignity Primary Care-based physician, unless the account for the facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I understand that I am responsible for any charges not covered by my insurance company.

PROMISE TO PAY

I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of Dignity Primary Care. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Dignity Primary Care visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Dignity Primary Care's Notice of Privacy Practices that provides information about how the Dignity Primary Care may use and disclose my protected health information.

I have read and understand the above information and give permission for my care as described. I understand that I have the right to OPT-OUT of any medical testing or treatment. I also understand that I may obtain further information regarding the health services offered by Dignity Primary Care by contacting (404) 588-0101.

Patient Name

Patient/Legal Representative Signature

Witness Signature

____/____/____
Date

____/____/____
Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please fill this page out if you would like to release your healthcare information to Dignity Primary Care

Patient Name: _____ Date of Birth: ____/____/____

Social Security Number: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Dignity Primary Care
328 W Main St Suite200
Lewisville TX 75057
Phone: (972) 537-5813 Fax: (972) 755-6786

This request and authorization applies to:

Healthcare information relating to the following treatment, conditions or dates:

☐ All healthcare information relating to the above OR

☐ Records only

☐ Lab results and X-ray/Radiology Reports

☐ Consultant Notes

☐ Other: _____

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Dignity Primary Care. ☐ Yes ☐ No

I understand that I have the right to withdraw this consent at any time upon written notice to the Dignity Primary Care Director.

Patient Signature

____/____/____
Date

Parent/Guardian Signature

____/____/____
Date

This Authorization Expires 180 Days After It Is Signed

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your relationship as our patient. We file insurance claims as a courtesy to our patients. The guidelines below help you assist us with this process.

- It is every patient's responsibility to understand their insurance policy and benefits.
- Payment is due at the time of services, including copayments, deductibles, and coinsurance.
- Each patient must bring their insurance information and a photo ID to every appointment to ensure correct processing of all insurance claims.
- All patients must complete and sign our Financial Policy before care is rendered.
- There is a \$ 35 fee for all returned checks.
- If you do not show up for an appointment or cancel with less than 24 hours notice, you will be charged \$25. You must pay this fee before you can schedule a new appointment. Patients with three missed appointments may be terminated from the practice.
- If your insurance company denies payment because of benefit limitations or non-covered services, you will be responsible for the charges.
- If your insurance company needs any additional information, you are responsible for providing it to them.

PATIENT OR RESPONSIBLE PARTY

I hereby assign the benefits from my insurance or any third party to Dignity Primary Care for medical services provided to me.

I have read, understand, and have been allowed to ask questions about this policy. I agree to comply with the guidelines above as described.

Signature _____

Printed Name _____ Date _____

DIGNITY PRIMARY CARE

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, disability or handicap, or source of payment for care or services.
2. **Respect and Dignity.** You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.
3. **Privacy and Confidentiality.** You have the right, within the law, to personal and informational privacy. This includes the right to:
 - Be interviewed and examined in surroundings that ensure reasonable privacy
 - Have a person of your own sex present during a physical examination or treatment
 - Not remain disrobed any longer than is required for accomplishing treatment or services
 - Request transfer to another treatment room if a visitor is unreasonably disturbing
 - Expect that any discussion or consultation regarding care will be conducted discreetly
 - Expect all written communications pertaining to care to be treated as confidential
 - Expect medical records to be read only by individuals directly involved in care, quality-assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

4. **Personal Safety.** You have the right to expect reasonable safety regarding the practice's procedures and environment.
5. **Identity.** You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.
6. **Information.** You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.
7. **Communication.** If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.
8. **Consent.** You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.
 - Consent discussions will include an explanation of the condition, the risks and benefits of treatment, as well as the consequences of no treatment.
 - Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.
 - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.
9. **Consultation.** You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.
10. **Charges.** Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.
11. **Rules and Regulations.** You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. **Keep Us Accurately Informed.** You have the responsibility to provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

2. **Follow Your Treatment Plan.** You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.
3. **Keep Your Appointments.** You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.
4. **Take Responsibility for Noncompliance.** You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.
5. **Be Responsible for Your Financial Obligations.** You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.
6. **Be Considerate of Others.** You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.
7. **Be Responsible for Lifestyle Choices.** Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

SIGNATURE OF PATIENT:

DATE:

DIGNITY PRIMARY CARE

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.

EFFECTIVE 04/16/2019

This Notice of Privacy Practices (the “*Notice*”) tells you about the ways we may use and disclose your protected health information (“*medical information*”) and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Dignity Primary Care, including its providers and employees (the “*Practice*”).

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers, and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been

rendered to you. If, however, you pay for an item or service in full, out of pocket, and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. [Address other reminders and other communications.] [Address other methods of communication, as applicable, such as email reminders.]

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose 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.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers’ Compensation. We may disclose medical information about you for your worker’ compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers’ compensation insurance or a state workers’ compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- 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.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental, or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your 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. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

[Z. Other. List any other special circumstances relating to uses and disclosures.]

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of “psychotherapy notes,” uses and disclosures of medical information for marketing purposes, and disclosures that constitute a “sale of medical information” under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice’s HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical 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 the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must

provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical 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.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to 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 can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to 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. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Dignity Primary Care
Attn: HIPAA Officer
328 W Main St, Suite 200 Lewisville TX 75057
972-537-5813

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____ Date: _____