ALLIANCE WOMEN'S HEALTHCARE

PATIENT DEMOGRAPHICS:

NAME: _____ **MAIDEN/FORMER NAME:** _____

TODAY'S DATE: _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

EMPLOYER: _____ WORK PHONE: _____

SPOUSE/PARTNER : _____ SPOUSE/PARTNER CELL: _____

PHARMACY:

PHARMACY NAME: _____ NUMBER: _____

STREET ADDRESS: _____

IF YOU ARE A MINOR (UNDER AGE 18) PLEASE PROVIDE PARENT INFORMATION:

MOTHER: _____ CELL: _____

FATHER: _____ CELL: _____

_____ INITIALS	Please use this email for my portal access: _____ I understand you will EMAIL me a notice that a statement has been generated by the portal. Please choose one: ☐ Alliance Women's Healthcare **MAY** leave voice mails regarding my treatment, results, and appointments. ☐ Alliance Women's Healthcare **MAY NOT** leave voice mails regarding my treatment, results, and appointments. Please use my _____ cell or _____ home number to leave voice mails.

INSURANCE – PRIMARY AND SECONDARY:

INSURANCE CARRIER: _____ GROUP ID: _____

POLICY NUMBER: _____ EFFECTIVE DATE: _____

CLAIMS ADDRESS ON BACK OF CARD: _____

CITY: _____ STATE: _____ ZIP: _____

PLAN PHONE NUMBER: _____

IF YOU ARE NOT THE POLICY HOLDER, PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE POLICY HOLDER:

NAME: _____ DATE OF BIRTH: _____

SSN OF POLICY HOLDER: _____ EMPLOYER: _____

IF YOU HAVE SECONDARY INSURANCE:

INSURANCE CARRIER: _____ GROUP ID: _____

ALLIANCE WOMEN'S HEALTHCARE

POLICY NUMBER: _____ EFFECTIVE DATE: _____

CLAIMS ADDRESS ON BACK OF CARD: _____

CITY: _____ STATE: _____ ZIP: _____

PLAN PHONE NUMBER: _____

IF YOU ARE NOT THE POLICY HOLDER, PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE POLICY HOLDER:

NAME: _____ DATE OF BIRTH: _____

SSN OF POLICY HOLDER: _____ EMPLOYER: _____

CONSENT TO MEDICAL CARE:

_____ INITIALS	I request treatment by Jonathan C Snead MD, PA d/b/a Alliance Women's Healthcare and it's agents and employees (hereinafter collectively "AWH"). I consent to the procedures which may be performed during my course of treatment, including emergency treatment or services that may include, but are not limited to, laboratory services, x-ray examination, diagnostic procedures, surgical treatment or procedures or services rendered to me as ordered by my physician or other healthcare professionals at AWH. I voluntarily consent to treatment, realizing that no guarantees have been given to me by AWH regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue treatment at any time. However, I understand that doing so may hinder my treatment and/or medical outcome. I understand I may have HIV testing performed and consent to the test.

DISCLOSURE OF INFORMATION:

_____ INITIALS

I agree that all records concerning my treatment shall remain the property of AWH. I understand that medical records and billing information generated or maintained by AWH are accessible to AWH personnel and medical staff. Personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in my continuum of care. AWH is authorized to disclose all or part of my medical record to any insurance company, third party payors, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of my account, unless AWH has received notice by me and services have been paid in cash in full as further described in AWH's Notice of Privacy Practices. AWH is authorized to disclose all or any portion of my medical record as set forth in AWH's Notice of Privacy Practices, unless I object in writing, and may do so electronically.

Primary Care or Specialist Disclosure

I have a PCP or specialist with whom AWH may disclose, if necessary, my medical records for their use. **Said disclosure may include HIV, STI, or genetic testing results.**

My PCP or specialist is: _____

Their fax number is: _____

Family Member Disclosure and Emergency Contact

I authorize AWH to disclose my medical records and protected health information (PHI) to the following person(s):

Name: _____ Relationship: _____

Phone Number: _____ May we contact them in an emergency? _____

Name: _____ Relationship: _____

Phone Number: _____ May we contact them in an emergency? _____

ALLIANCE WOMEN'S HEALTHCARE

	Name: _____Relationship:_____ Phone Number: _____May we contact them in an emergency? _____ **PREGNANT PATIENTS ONLY:** My initials to the left indicate my consent to send my records, including STI and HIV testing results, to Texas Health Resources Hospital at Alliance ("THR"). If during the course of my pregnancy it becomes necessary to refer me to a high risk physician or other physician for continued treatment, my initials to the left indicate I consent to have my records, which may include STI and HIV testing results, sent for my treatment and continuation of care. *Please note: Read the Notice of Privacy Practices to fully understand the use and disclosure of your medical information.*
AUTHORIZATION AND ACKNOWLEDGEMENT TO DISCLOSE HIV AND STD INFORMATION	
_____ INITIALS	I specifically authorize Jonathan C. Snead, M.D., P.A. d/b/a Alliance Women's Healthcare "Alliance Women's Healthcare" or its designated employee(s) and agents to disclose my Protected Health Information, including HIV test results and HIV related information and other information related to sexually transmitted diseases, to any healthcare provider involved in my treatment or upon a transfer of records from AWH to another healthcare provider for the purpose of treatment. I understand that Section 181.103 of the Texas Health and Safety Code permits AWH to release HIV test results, without my consent, for various purposes including but not limited to the physician or other person authorized by law who ordered the test or a physician, nurse, or other health care personnel who has a legitimate need to know the test result to provide for their protection and my health and welfare. Said disclosure may be in electronic form.
AUTHORIZATION AND ACKNOWLEDGEMENT TO DISCLOSE GENETIC INFORMATION	
_____ INITIALS	I understand I may have genetic testing during my care. In the event I do, I authorize the disclosure of these results to any healthcare provider involved in my treatment (my PCP or a physician or specialist I am referred to) or upon a transfer of records to another healthcare provider. I am consenting to disclose the results of any genetic testing performed under the direction of Jonathan C. Snead MD PA d/b/a Alliance Women's Healthcare or its designated employee(s) and agents. I specifically authorize AWH to disclose the genetic tests indicated by a check below and related information to healthcare providers involved in my treatment for the purpose of treatment. ☐ Myriad to the following provider: _____ ☐ Q Natal to the following provider: _____ ☐ Other: _____ to the following provider: _____
LEGAL ASSIGNMENT AND BENEFITS OF AUTHORIZED REPRESENTATIVE	
_____ INITIALS	I understand and agree that I am financially responsible for charges incurred by me for services rendered by AWH and, to the extent that I have insurance and/or employee health care benefits coverage I hereby assign and convey directly to AWH, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from AWH, regardless of AWH's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges incurred by me regardless of any applicable insurance or benefit payments. I authorize AWH to release all medical information necessary to process my claims under HIPAA. I authorize any plan administrator or fiduciary, insurer and my attorney to release to AWH any and all plan documents, insurance policy and/or settlement information upon written request from AWH in order to claim such medical benefits, reimbursement or any applicable remedies to which I am entitled. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

	I convey to AWH, to the full extent permissible under the law, including but not limited to, ERISA §502(a)(I)(B) and §502(a)(3), all rights and benefits I may have under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, appropriate equitable relief, surcharge remedy, or other right with respect to any and all medical expenses incurred as a result of the medical services I received from AWH, and to the full extent permissible under the law to claim or file a lien to such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to: (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice or document to pursue appeal proceedings; and (5) taking any administrative and/or judicial actions by such provider(s) to pursue such claim or right against any liable party or employee group health plan(s), including, if necessary, AWH filing a lawsuit against any such liable party or employee group health plan in my name with derivative standing but at AWH expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.
UNBORN CHILD COVERAGE:	
_____ INITIALS	If pregnant, the above consent for treatment, releases, assignments and guarantor agreement apply to my newborn child during the period of treatment.
INSURANCE PRECERTIFICATION:	
_____ INITIALS	I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:	
_____ INITIALS	A description of how medical information will be used and disclosed is summarized on the Notice of Privacy Practices. A complete copy of the Notice of Privacy Practice is included on the back of these intake forms. By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Privacy Officer at 10600 North Riverside Drive, Suite 100, Fort Worth TX 76244, (817) 741-9663. I also understand there is a copy of the Notice of Privacy Practice on the website www.alliancewomenshealthcare.com.
ACKNOWLEDGEMENT TO RECEIVE PAST MEDICATION HISTORY:	
_____ INITIALS	I authorize Jonathan C Snead MD, PA d/b/a Alliance Women's Healthcare's agents and employees to electronically obtain my current and past medication history. This may include a history of HIV or psychiatric medications.
FINANCIAL AGREEMENT ACKNOWLEDGEMENT	
_____ INITIALS	I have read the Financial Agreement and signed it. I understand this is listed on the AWH website, www.alliancewomenshealthcare.com, and a paper copy is available upon request.
PATIENT PORTAL	
_____ INITIALS	I understand AWH uses an online patient portal. I understand I may access this at any time through the website, www.alliancewomenshealthcare.com, to see my current information, may update my demographic information, insurance information, and may make payment through use of the portal. Please call our office if you have a problem with the site.

ALLIANCE WOMEN'S HEALTHCARE

PERSONAL DEMOGRAPHIC INFORMATION INCLUDING CURRENT INSURANCE INFORMATION:	
_____ INITIALS	I understand I must contact AWH when I have a change in insurance during my care. Failure to do so may cause claims to be denied for non-coverage/failure to have coverage/failure to timely file with the proper insurance carrier. In those instances, I understand I may be held responsible for charges that were not covered or denied for any reason. I understand I must contact AWH to update my address and contact information. I understand I must contact AWH if I have any changes to this paperwork – including my disclosure authorization and emergency contact information (said changes must be in writing and received by AWH to be effective per our Notice of Privacy Practices).

I, the undersigned, as the patient, parent, guardian, spouse, guarantor, or agent of the patient, hereby certify I have read, and fully and completely understand this Intake Form and freely and voluntarily agree to be bound by its terms.

SIGNATURE: _____ DATE: _____

Printed Patient Name: _____

If signed by someone other than the Patient, indicate your name:

Printed Name:_____
Relationship to Patient: _____

NOTE: If you are signing for a Minor, please make sure the contact information is for the PATIENT and not yourself. Thank you.

ALLIANCE WOMEN'S HEALTHCARE
DR. JONATHAN SNEAD, FACOG
& ANGELA GEORGE, WHNP
OBSTETRICS / GYNECOLOGY / INFERTILITY

Financial Agreement - 2019

Parties – Jonathan C. Snead, MD PA d/b/a Alliance Womens Healthcare (otherwise known as "we" "our" "us" or "Alliance Women's Healthcare") and _____ (otherwise known as "you" "your"). The "claim" is based on the services provided for any given date of service. There may be more than one "claim" as well as more than more than one "date of service" or "service" provided. This Agreement contemplates all claims for all services rendered on any given day.

The parties agree to the following:

- It is your responsibility to provide us with your most current insurance information. If you change insurance or fail to maintain insurance, you must notify our office immediately if you are a current patient. A "current patient" is any OB patient who has not delivered or any other patient who has an appointment of any kind.
- If you fail to provide accurate insurance to us information in a timely manner (prior to your insurance termination), your insurance company may deny your claim. If the claim is denied, you will be financially responsible for services rendered.
- Please note, as medical providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand your benefits and eligibility.
- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid. **Failure to do so may result in your full financial responsibility.**
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **Therefore, you are financially responsible for services not covered by your insurance company. It is your responsibility to know your benefits.**
- Prior to receiving services, you must verify that we are participating providers for your insurance company by calling your insurance company or logging into your carrier's website.
- We charge what is usual and customary for our area. You are responsible for payment if your insurance company disputes payment for your claim.
- Copayments, coinsurance and/or deductibles are typically due at the time of service. We will provide a good-faith estimate the amount you owe based on information we receive from your insurance company. This will only be an estimate and in no way does it imply a contractual arrangement indicating an agreed upon amount actually due. We will not know how much is actually due by you until we receive payment from your insurance company.
- You are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation. Please review your explanation of benefits or contact your insurance company if you have any questions.
- **We must have a current copy of your insurance card on file. We require a copy of your driver's license/picture ID and insurance card at every visit.**
- You must provide your most current billing address, telephone numbers and any other important contact information. If your address or contact information changes, modifications can be made via our secure patient portal at www.alliancewomenshealthcare.com
- We will send a statement to the billing address on file to notify you of any balances you may owe. If you have any questions regarding your balance, it is your responsibility to contact our office after receipt of the initial statement. We will assume you do not dispute the charges if you do not contact our office within 30 days of receipt of a statement.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity**. You will be responsible to pay all collection costs incurred, including but not limited to attorney's fees, court costs and interest if applicable. The laws of the state of Texas apply and venue is proper in Tarrant County.
- If you are not able to pay the balance due in full, you must contact our office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Alliance Women's Healthcare.
- All returned checks are subject to a $35.00 charge in addition to your original balance.
- At our discretion, we may charge you a $50.00 "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- Full payment is due at the time of service. We accept cash, checks and most major credit cards.

PATIENT NAME PRINTED: _____ **DATE OF BIRTH:** _____
PATIENT SIGNATURE: _____ **TODAY'S DATE:** _____

2019 NOTICE OF PRIVACY PRACTICES FORM

Effective Date:_____ Revised 1/2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ALLIANCE WOMEN'S HEALTHCARE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about your rights or this Notice, please contact:
Darla Snead at 817-741-9663

Who Will Follow This Notice?

1. Alliance Women's Healthcare;
2. Alliance Women's Healthcare's affiliated practices, employees, agent and assigns; and
3. Alliance Women's Healthcare's subcontractors.

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care from Alliance Women's Healthcare, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

1. Basis for planning your treatment and services;
2. Means of communication among the physicians and other health care providers involved in your care;
3. Means by which you or a third-party payor can verify that services billed were actually provided;
4. Source of information for public health officials; and
5. Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

Our Responsibilities

Alliance Women's Healthcare is required by law to:

1. Maintain the privacy and security of your medical information;
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
3. Abide by the terms of this notice;
4. Notify you if we are unable to agree to a requested restriction;
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations; and
6. Notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information. We are required by law to notify you following a breach of unsecured protected health information. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.
7. To disclose, upon request, to you or another person named by you an electronic copy of your medical records. Texas law requires, however, that we first obtain your written authorization prior to disclosing electronically.

The Methods in Which We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. **For Treatment**. We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
2. **For Payment**. We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
3. **For Health Care Operations**. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Alliance Women's Healthcare in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
4. **Appointment Reminders**. We may use and disclose medical information in order to remind you of an appointment. For example, Alliance Women's Healthcare may provide a written or telephone reminder that your next appointment with Alliance Women's Healthcare is coming up.
5. **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
6. **As Required by Law**. We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
7. **To the Department of Health and Human Services**. We will share information about you with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
8. **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

9. **Sale of Practice**. We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

Special Situations

1. **Organ and Tissue Donation**. If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
2. **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
3. **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
4. **Qualified Personnel**. We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
5. **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following activities:

    a. To prevent or control disease, injury, or disability;
    b. To report reactions to medications or problems with products;
    c. To notify people of recalls of products they may be using;
    d. 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; and
    e. To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.
    f. All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

6. **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. 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, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
7. **Lawsuits and Disputes**. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
8. **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

    a. In response to a court order or subpoena; or
    b. If Alliance Women's Healthcare determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

9. **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner when authorized by law (*e.g.*, to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
10. **Inmates**. If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
11. **Other Uses or Disclosures**. Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.
12. **Electronic Disclosure.** We may use and disclose your medical information electronically. For example, if another provider requests a copy of your medical record for treatment purposes, we may forward such record electronically. Under Texas law, we are required to obtain your written authorization before we disclose your PHI, except to another covered entity for treatment, payment, and permissible health care operations.

DISCLOSURES REQUIRING AUTHORIZATION

1. **Psychotherapy Notes**. Psychotherapy notes are notes by a mental health professional that document or analyze the contents of a conversation during a private counseling session – or during a group, joint, or family counseling session. If these notes are maintained separate from the rest of your medical records, they can only be used and disclosed as follows. In general, psychotherapy notes may not be used or disclosed without your written authorization, except in the following circumstances.

    Psychotherapy notes about you may be used and disclosed without your written authorization in the following situations:

    a. The mental health professional who created the notes may use them to provide you with further treatment;
    b. The mental health professional who created the notes may disclose them to students, trainees or practitioners in mental health who are learning under supervision to practice or improve their skills in group, joint, family, or individual counseling;
    c. The mental health professional who created the notes may disclose them as necessary to defend himself or herself or Alliance Women's Healthcare in a legal proceeding initiated by you or your personal representative;
    d. The mental health professional who created the notes may disclose them as required by law;

e. The mental health professional who created the notes may disclose the notes to appropriate government authorities when necessary to avert a serious and imminent threat to the health or safety of you or another person;

f. The mental health professional who created the notes may disclose them to the United States Department of Health and Human Services when that agency requests them in order to investigate the mental health professional's compliance, or Alliance Women's Healthcare's compliance, with Federal privacy and confidentiality laws and regulations; and

g. The mental health professional who created the notes may disclose them to medical examiners and coroners, if necessary, to determine your cause of death.

All other uses and disclosures of psychotherapy notes require your written authorization. You have the right to revoke such authorization in writing.

2. **Marketing.** Marketing *generally* includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. For example, marketing includes communications to you about new state-of-the-art equipment if the equipment manufacturer pays us to send the communication to you. We will obtain your written authorization to use and disclose PHI for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law.
All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.

3. **Fundraising**. We do not use and disclose your information for fundraising purposes.

4. **Sale of Your Medical Information**. Alliance Women's Healthcare will not sell your medical information for marketing purposes. However, there are instances in which Alliance Women's Healthcare will sell your PHI. For example, should Alliance Women's Healthcare merge or the practice is sold to another physician group, your medical record may be part of the asset transfer.

Any other Sale of Protected Health Information requires your written authorization. You have the right to revoke such authorization in writing.

5. **Uses and Disclosures Requiring an Opportunity to Agree or Object**. Please note that HIPAA permits us, in certain circumstances, to disclose your medical information without your authorization (including facility directors, emergency circumstances, and disclosure to relatives). Texas law is stricter. Therefore, we will not disclose your information for these purposes without first obtaining your explicit authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

1. **Right to Inspect and Copy**. The right to inspect and receive a copy of medical information that may be used to make decisions about your care. This includes the right to direct us to transmit a copy of your medical information to a designated person or entity of your choice. Usually, this includes medical and billing records. Upon your request, Alliance Women's Healthcare will provide a copy of such records as soon as possible, and within fifteen (15) days of your request.

To inspect and receive a copy of your medical information or to direct us to provide a copy of your choosing, you must submit your request in writing or electronically to the Privacy Officer for Alliance Women's Healthcare. If you request a copy of the information, Alliance Women's Healthcare may charge a fee for the costs of copying, mailing, or summarizing your records. We will inform you of all fees in advance. You can also ask to see or get an electronic copy of health information we have about you. Please contact our Privacy Officer at 817-741-9663 with any questions you have on how to request access, receive a copy, or how to direct us to transmit your information to a designated person or entity. On our website (www.obgyn-alliance.com), there may be a fee schedule for copies and/or summaries of medical records.
Alliance Women's Healthcare may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Alliance Women's Healthcare will review your request and denial. The person conducting the review will not be the person who denied your request. Alliance Women's Healthcare will comply with the outcome of the review.

2. **Right to Amend**. If you feel that medical information maintained about you is incorrect or incomplete, you may ask Alliance Women's Healthcare to amend the information. You have the right to request an amendment for as long as the information is kept by Alliance Women's Healthcare.

To request an amendment, your request must be made in writing and submitted to Alliance Women's Healthcare. In addition, you must provide a reason that supports your request.

Alliance Women's Healthcare 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, Alliance Women's Healthcare may deny your request if you ask us to amend information that:

- Was not created by Alliance Women's Healthcare, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Alliance Women's Healthcare;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

3. **Right to an Accounting of Disclosures**. To request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

To request this list you must submit your request in writing to Darla Snead, Privacy Officer. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Alliance Women's Healthcare 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.

4. **Right to Request Restrictions**. To request a restriction or limitation on the medical information Alliance Women's Healthcare uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Alliance Women's Healthcare discloses about you to someone who is involved in your care or the payment for your care.

Alliance Women's Healthcare is not required to agree to your request, unless the request pertains solely to a health care item or service for which Alliance Women's Healthcare has been paid out of pocket in full and: (i) the restriction pertains to payment or a health care operation and (ii) the disclosure is not otherwise required by law. Should Alliance Women's Healthcare agree to your request, Alliance Women's Healthcare will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions you must make your request in writing to Alliance Women's Healthcare. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Alliance Women's Healthcare's use and/or disclosure; and (3) to whom you want the limits to apply.

5. **Right to Request Confidential Communications**. To request that Alliance Women's Healthcare communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Alliance Women's Healthcare contact you only at work or by mail.

To request that Alliance Women's Healthcare communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Alliance Women's Healthcare will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. **Right to Revoke an Authorization**. There are certain types of uses or disclosures that require your express authorization. For example, Alliance Women's Healthcare may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting Darla Snead, Privacy Officer, at 10600 North Riverside Drive, Suite 100, Fort Worth, Texas 76244 or DSnead@obgyn-alliance.com. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.

7. **Right to Receive a Copy of this Document**. You have a right to obtain a paper copy of this document upon request.

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Alliance Women's Healthcare or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Alliance Women's Healthcare, contact the Privacy Officer at 817-201-9378. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.
You will NOT be penalized for filing a complaint.

ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth:_____

I acknowledge that Alliance Women's Healthcare provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient