Date: _____/_____/_____ Patient Number: _____

Name: _____ Age: _____ Height: _____ Weight: _____
Last name First name Middle Initial

Date of Birth: _____/_____/_____ Male ❑ Female ❑ Body Part to be Examined: _____
month day year

Address: _____ Telephone (home): (_____) _____ - _____

City: _____ Telephone (work): (_____) _____ - _____

State: _____ Zip Code: _____

Reason for MRI and/or Symptoms: _____

Referring Physician: _____ Telephone: (_____) _____ - _____

---

1. Have you had prior surgery or an operation (e.g., anthroscopy, endoscopy, etc.) of any kind? ❑ No ❑ Yes
   If Yes, please indicate the date and type of surgery:
   Date: _____/_____/_____ Type of surgery: _____
   Date: _____/_____/_____ Type of surgery: _____
2. Have you had prior therapy for back pain? ❑ No ❑ Yes **If yes, please specify:** _____ **Type** _____ **Date** _____
3. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❑ No ❑ Yes
   If yes, please list:

	Body Parts	Date	Facility
MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other _____	_____	_____/_____/_____	_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑ No ❑ Yes
   If yes, please describe: _____
5. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❑ No ❑ Yes
   If yes, please describe: _____
6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑ No ❑ Yes
   If yes, please describe: _____
7. Are you currently taking or have you recently taken any medication or drug? ❑ No ❑ Yes
   If yes, please list: _____
8. Are you allergic to any medication? ❑ No ❑ Yes
   If yes, please list: _____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast Medium or dye used for an MRI, CT, or X-ray examination? ❑ No ❑ Yes
10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, diabetes, on dialysis, renal or liver transplant, or seizures? ❑ No ❑ Yes
    If yes, please describe: _____

For Female Patients:

11. Date of last menstrual period: _____/_____/_____ Post menopausal? ❑ No ❑ Yes
12. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes
13. Are you currently breast feeding? ❑ No ❑ Yes

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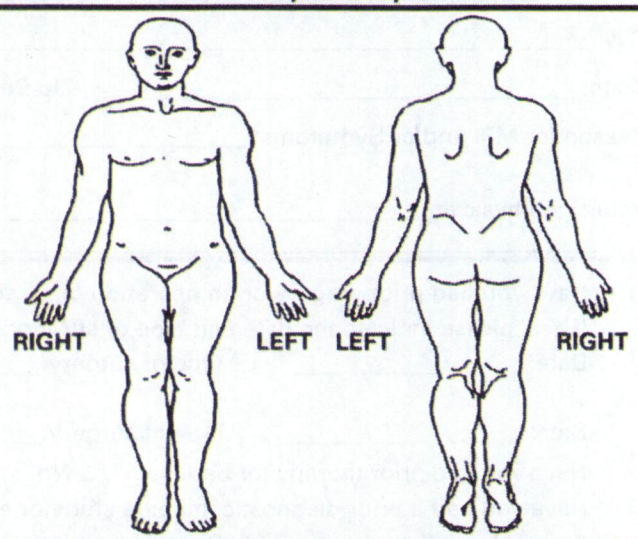
Magnetic Resonance (MR) Procedure Screening Form For Patients

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR Spectroscopy). **Do not enter** the MR System room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

❑ Yes	❑ No	Claustrophobia
❑ Yes	❑ No	Aneurysm clip(s)
❑ Yes	❑ No	Any metallic fragment or foreign body (orbits)
❑ Yes	❑ No	Any type of prosthesis (eye, penile, etc.)
❑ Yes	❑ No	Aphasia
❑ Yes	❑ No	Artificial or prosthetic limb
❑ Yes	❑ No	Body piercing jewelry
❑ Yes	❑ No	Bone growth/bone fusion simulator
❑ Yes	❑ No	Bone/joint pin, screw, nail, wire, plate, etc.
❑ Yes	❑ No	Breathing problem or motion disorder
❑ Yes	❑ No	Cardiac pacemaker
❑ Yes	❑ No	Cochlear, otologic, or other ear implant
❑ Yes	❑ No	Dentures or partial plates
❑ Yes	❑ No	Electronic implant device
❑ Yes	❑ No	Eyelid spring or wire
❑ Yes	❑ No	Hearing and (Remove before entering MRI room)
❑ Yes	❑ No	Heart valve prosthesis
❑ Yes	❑ No	IUD, diaphragm, or pessary
❑ Yes	❑ No	Implanted cardioverter defibrillator
❑ Yes	❑ No	Implanted drug infusion device
❑ Yes	❑ No	Insulin or other infusion pump
❑ Yes	❑ No	Internal electrodes or wires
❑ Yes	❑ No	Joint replacement (Hip, knee, etc.)
❑ Yes	❑ No	Magnetically-activated implant or device
❑ Yes	❑ No	Medication patch (Nicotine, Nitroglycerine)
❑ Yes	❑ No	Metallic stent, filter, or coil
❑ Yes	❑ No	Nuerostimulation system
❑ Yes	❑ No	Other Implant_____
❑ Yes	❑ No	Radiation seeds or implants
❑ Yes	❑ No	Shunt (Spinal or intraventricular
❑ Yes	❑ No	Spinal cord stimulator
❑ Yes	❑ No	Stroke
❑ Yes	❑ No	Surgical staples, clips, or metallic sutures
❑ Yes	❑ No	Swan-Ganz or thermodilution catheter
❑ Yes	❑ No	Tattoo or permanent makeup
❑ Yes	❑ No	Tissue expander (e.g., breast)
❑ Yes	❑ No	Vascular access port and/or catheter
❑ Yes	❑ No	Wire mesh implant
❑ Yes	❑ No	Combative or can not hold still for 30 minutes

Please mark on the figure(s) below the location of any implant or metal inside of, or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: Notify MRI immediately if yes to any of the above.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious to fatal effects by receiving gadolinium based contrast agents.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: ❑ Patient ❑ Relative ❑ Nurse: _____
Print Name Relationship to Patient

Form Information Reviewed By: _____
Print Name Signature Date/Time

❑ MRI Technologist ❑ Nurse ❑ Radiologist ❑ Other: _____

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Magnetic Resonance (MR) Procedure Screening Form For Patients

Patient History Pre-IV Contrast Form

For **Gadolinium** based Contrast used in MRI

Name: _____ Sex ❒ Male ❒ Female DOB _____

Allergies ❒ Yes ❒ No if yes, please list: _____ Check if Allergy Pre-Medication Protocol Followed

Date of Pre-Medication Protocol _____

Height: _____ Feet _____ in Weight: _____ (lbs) Race ❒ Black ❒ White ❒ Hispanic ❒ Asian ❒ Other

What symptoms brought you to the center? _____

Were you injured? ❒ Yes ❒ No ❒ N/A How? _____ When? _____

PATIENT HISTORY

Have you experienced any of the following? (for Outpatients and Emergency Center patients only) Black Ink Only

YES	NO		YES	NO	
❒	❒	Renal (kidney) Disease * †	❒	❒	Hypertension (high blood pressure) *
❒	❒	Renal (kidney) Surgery *	❒	❒	Asthma †
❒	❒	Multiple Myeloma * †	❒	❒	Congestive Heart Failure †
❒	❒	IDDM	❒	❒	History of Cancer Type: _____
❒	❒	Liver transplant/pending liver transplant?	❒	❒	Prior Surgery Type: _____
❒	❒	Have you received contrast media prior to this exam?			
❒	❒	If yes, did you have a reaction to the contrast agent?			
❒	❒	Describe reaction: _____			
❒	❒	Has the patient had the requested contrast type in the past 24 hours?			

If Yes - Date: _____ Exam Type: _____

KEY: * = GFR calculation is required if yes
† = May authorize Visipaque if yes

Medication History *(for outpatients and Emergency Center patients only) Please provide information about each prescription medication, herbal supplement, over the counter (OTC) medication that you are currently taking.*

DRUG NAME	DOSE STRENGTH/QUANTITY	ROUTE (ORAL, IV, ETC.)	HOW OFTEN	LAST DOSE DATE/TIME
1.				
2.				
3.				
4.				
5.				

FEMALE PATIENTS

YES	NO		YES	NO	
❒	❒	Have you had a hysterectomy?	❒	❒	Any possibility that you are pregnant?
❒	❒	Were your ovaries removed?			Date of last menstrual period? _____
❒	❒	Do you have a positive pregnancy test now?			Total pregnancies: _____
		If yes, by: ❒ Blood ❒ Urine			Miscarriages: _____
		If yes, when did you test positive: _____	❒	❒	Are you breast feeding?

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OFFICE USE ONLY

Route of administration is IV: Frequency is once

☐ ____ ml **Multihance (0.2ml / kg Maximum Dose 20ml)**

☐ ____ ml Other _____

Lot # _____

IV started by _____
Print Name Signature

Date _____ Time _____ IV Gauge: _____ IV Site: _____

Pregnancy Test Results: ☐ **Positive** ☐ **Negative (Reference range; Negative) Date/Time Collection:** _____

Istat used ☐ **Yes** ☐ **No BMI:** _____

Creatinine: _____ **0.5 - 1.4 mg/dl Date/Time Collection:** _____ **Estimated GFR:** _____ **ml/min/1.73m2**

30 or below for CT/Xray, 60 or below for MRI/Pedi, Signature _____

Glucose: _____ **70 - 99 mg/dl Date/Time Collection:** _____

Radiologist approving contrast if applicable: Dr.: _____

Technologist Comments:

COMMENTS: _____

_____

_____

☐ Yes ☐ No is the patient a suspected victim of abuse?

☐ Yes ☐ No Is the patient a fall risk?

☐ Yes ☐ No Patient tolerated exam

☐ Yes ☐ No Patient discharged without complaint

_____ _____ _____ _____
Technologist/Nurse's Signature Print Name Date Time

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Patient History
Pre-IV Contrast Form

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REGISTRATION INFORMATION

PATIENT LAST NAME: _____ FIRST NAME: _____

DOB: _____ SS#: _____ SEX: M_____ F_____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP:_____

EMAIL: _____ HM#: _____ CELL: _____ WK#: _____

EMERGENCY CONTACT: _____ RELATION: _____ PH#: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED

PERFERRED LANGUAGE: _____ RELIGIOUS PREFERENCE: _____

RETIRED (CIRCLE ONE) YES / NO RETIREMENT DATE_____ DISABLED YES / NO DISABILITY DATE:_____

INSURANCE NAME: _____ SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE MOTHER FATHER W/C

NAME OF INSURED: _____ DOB: _____

INSURANCE NAME: _____ SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE MOTHER FATHER W/C

NAME OF INSURED: _____ DOB: _____

IS THIS VISIT DUE TO A WORK RELATED INJURY? YES NO | IF ANSWER IS "NO" PLEASE SKIP THIS SECTION

EMPLOYER AND INSURANCE NAME_____ **PHONE #** _____

EMPLOYER ADDRESS _____ **CITY/STATE/ZIP** _____

DATE OF INJURY _____ **TIME OF INJURY**_____ **CLAIM#**_____**AREA**_____

ADJUSTER NAME_____ **PHONE#**_____

Ethnicity Question:

Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds. The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving adequate healthcare.

Nationality or Ethnic Background (select one)

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I (patient or legal guardian) refuse to answer the question.

Race (select one)

- ☐ American Indian/Eskimo/Aleut
- ☐ Asian or Pacific Islander
- ☐ Black
- ☐ White
- ☐ Other
- ☐ I (patient or legal guardian) refuse to answer the question

Patient/Patient Representative Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient Signature of Patient

_____ / _____ / _____

Date Signed

_____ _____

Name Patient's Personal Representative Signature of Patient's Personal Representative

_____ / _____ / _____

Date Signed

FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other _____

_____

1 - 3-2021 (Version: As noted on NPP) __03__/ __01__/ __2021__ (Date: As noted on NPP)

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

PATIENT ID

PATIENT CONSENT AND ADMISSION AGREEMENT

CONSENT TO MEDICAL PROCEDURES- The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis including emergency treatment or services, and which may include but not limited to laboratory procedures, x-ray examinations, medical treatment or procedures, or hospital services rendered the patient under the general and special instructions of the patient's physician.

FINANCIAL AGREEMENT- The undersigned agrees, whether he signs as agent or a patient, that in consideration of the services to be rendered to the patient, he hereby is responsible for paying facility copayments, deductibles, estimated facility coinsurance amounts; and any balance deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashier's check, credit card, Care Credit or personal check. Self-pay and cosmetic surgery procedures must be paid in full to prior to surgery.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION- In consideration for services rendered, I hereby transfer and assign to the hospital and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance. I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to Memorial Hermann Surgical Hospital Kingwood **MHSHK**, my attending physician, consulting physician, anesthesiologist, radiologists, ER physicians, professional laboratory and pathology services recognize the above physician/services are independent contractors who will generate separate bills for their respective services and I am financially responsible for all. **MHSHK** provides cost estimates and generates bills for the facility portion only. **MHSHK** files primary and secondary insurance claims for patients who are not scheduled as self-pay. I authorize **MHSHK** and/or physicians/services indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, health or hospital plan.

(Please initial below of acknowledgement)

_____ I acknowledge that one or more of the physicians providing my treatment at MHSHK may have an ownership interest in the hospital. I may request a list of the hospital owners from the front desk receptionist.

_____ I acknowledge that I have the right to choose the provider of my healthcare services and have chosen MHSHK.

_____ I acknowledge that this facility does not provide 24/7 physician coverage in-house;

_____ I acknowledge there is a physician on call 24/7. In case of an emergency that exceeds the capability of this facility, I understand that I may be transferred to a local acute care hospital.

TELEMEDICINE- I understand that techniques of telemedicine may be employed to facilitate the patient's care. Techniques include, but are not limited to electronic transmission of radiographic images (X-rays), remote access to laboratory results, electronic transmission of vital signs and/or remote monitoring of life support equipment. Techniques of telemedicine also include bedside video imaging of patients. For example, the Patient may be monitored by camera while the Patient is undergoing care in the Emergency Treatment Area or Inpatient Unit. All electronic transmission of data will be restricted to authorized Physicians or care provider's staff and will be performed in compliance with confidentiality guidelines of the Federal Health and Portability and Accountability Act (HIPAA) and applicable state privacy laws. I also understand that I have the right, at any time, to refuse telemedicine monitoring of Patient by informing the treating Physician of my objection.

MEDICARE PAYMENTS- (Patient's certification, Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder, medical or other information about me to release to the Social Security Administration, its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLE AUTHORIZATION- I have been informed and understand that the MHSHK WILL NOT ASSUME RESPONSIBILITY for any personal property I may bring and/or keep in the hospital during my stay at MHSHK.

ADVANCED MEDICAL DIRECTIVE

____ I have an Advanced Directive located at _____.

____ I have provided a copy of my Advanced Directive to **MHSHK.**

____ I wish to enact an Advanced Directive to physicians to accept or refuse medical treatments and informed of my rights.

____ I am not interested in an Advanced Directive at this time.

PRIVACY NOTICE-PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT: (Please initial below of acknowledgement)

_____ I have received Version 1-Notice of Privacy Practice 03/2021 for MHSHK.

_____ I have received a copy of the Patient Rights and Responsibilities.

_____ I acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, explains how to register any complaints I may have.

_____ I **DO** want the hospital to notify a family member/representative and/or my physician in the event of my admission.

Family/Representative Name_____ **Phone:** _____

Physician Name: _____ **Phone:** _____

_____ I **DO NOT** want the hospital to notify a family member/representative and/or my physician in the event of my admission.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER- I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, the hospital may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERM.

_____ _____

Date Patient, Patient's Agent or Representative

_____ _____

Witness Relationship to Patient

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Kingwood

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Place Patient Identification Label Here

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Memorial Hermann Surgical Hospital Kingwood, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.

If an email address has been provided Memorial Hermann Surgical Hospital Kingwood its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Memorial Hermann Surgical Hospital Kingwood when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? **(If no, please provide an alternate mailing address below.)**

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	**Telephone**
Spouse	_____	_____
Caretaker	_____	_____
Child	_____	_____
Parent	_____	_____
Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

MEMORIAL HERMANN
Surgical Hospital
Kingwood

Day of procedure driver's name _____ **Phone**_____

Patient Portal:
The patient portal is a secure way to access your medical records. Examples: educational, documents, medications, procedures and visit summaries. We are offering the patient portal as a convenience to you at no cost. We will not sell or give away any private information, including email addresses. The portal is for non-emergency use only. By using this online patient portal, you agree to protect your password from any unauthorized individuals. We will register you and send you an invite via email. Please provide the email address you wish to use as well as the answer to the challenge question; which is the last four digits of your social security number. You will be prompted to change your password the first time logging in.

Patients' email address: _____

Security Answer: Last for digits of your SSN _____

Patient Signature: _____ Date:_____

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle):	Date of Birth:

Information that will be Disclosed; Purpose of the Consent for Disclosure

I hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE).

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. HOWEVER, IF YOU DO NOT SIGN [AND INITIAL) THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

Individual Signature

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representive's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT IF YOU WISH.

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What Services are Covered?

The Financial Assistance Policy (FAP) covers emergency and medically-necessary services provided at a Memorial Hermann Hospital. The policy does *NOT COVER*: cosmetic procedures, services provided by physicians and other providers who treat you at a Memorial Hermann Hospital but are not employed by the Hospital, or providers who bill separate from the Hospital for their services.

How to Apply

The FAP and Application may be obtained in-person, via mail, via telephone and from the Memorial Hermann website. Complete the application, include the requested documents and submit to the Hospital Admission/Registration Department *or* to the address listed on the back of this brochure.

Income Limits

One of the qualifying factors is income based on the table below:

2019 POVERTY GUIDELINES	
Persons in family/household	Income per Year
1	$ 12,490
2	$ 16,910
3	$ 21,330
4	$ 25,750
5	$ 30,170
6	$ 34,590
7	$ 39,010
8	$ 43,430
For families/households with more than 8 people: add $4,420 for each additional person.	

Who Qualifies for Financial Assistance?

The amount of financial assistance depends on your income, size of your family and assets. Patients with family income of 200% of the Federal Poverty Level or less may be eligible for a discount of 100%. Patients with family income of over 200% of the Federal Poverty Level may be eligible for a discount.

Patient Financial Assistance Summary

Memorial Hermann Health System offers *financial assistance* to eligible patients based on income and assets for partially or fully discounted emergent or medically-necessary care.

Patients seeking *financial assistance* must apply for the program.

To see if you qualify for financial assistance* and *for free confidential help in applying, contact:

Patient Business Services
300 Kingwood Medical Drive
Kingwood, TX 77339
Attention: Financial Assistance
Phone: 281-312-4012

MemorialHermannKingwood.com/Financial-Information

A FREE copy of the Financial Assistance Policy and the Financial Assistance Application are available in English and Spanish by:

- Calling 281-312-4012 or 281-312-4000
- Requesting an application by mail: 300 Kingwood Medical Drive, Attn: Financial Assistance Kingwood, TX 77339
- Downloading an application from the Hospital Website at the above link.

The following forms of ***picture*** identification are acceptable for proof of identity:

State-issued driver license or identification card
Passport (US or foreign)
Identification card issued by Foreign Consulate
Student identification card
U.S. immigration document
Credit card (with photo)

FINANCIAL INFORMATION FORM / FINANCIAL ASSISTANCE APPLICATION

For assistance completing this form or if you have questions, please call 281-312-4068

Patient Name:

Patient Street Address: City, State, Zip Code:

Account Number(s): Date(s) of Service:

INSTRUCTIONS: All questions must be answered. If a question does not pertain, write N/A on the line.
Attach a photocopy of one proof of identity with a picture (example: state-issued driver license or Passport with picture, etc.) *
Attach a photocopy of the most recent Income Tax return *or*
Attach a photocopy of one of the following proofs of income:

** If photo ID is not available, other documents showing identity may be used. Contact phone number above for assistance.*

- ☐ Last 2 paycheck stubs
- ☐ Unemployment benefit confirmation slip
- ☐ Social Security check or award letter
- ☐ Letter from employer stating employee name, occupation, hourly wage, number of hours worked

****** This is not considered a complete application without the supporting documentation. ******

STATUS:	☐ Permanent Texas Resident	☐ Legal Resident	☐ Immigrant Visa	☐ Non-Immigrant Visa
MARITAL STATUS (check one):	☐ Married ☐ Widowed	☐ Single ☐ Other	☐ Divorced	

CHILDREN UNDER 18 YEARS OLD AND OTHER DEPENDENTS WITHIN THE HOUSEHOLD (Continue on another page, if needed)

Full Name	Date of Birth	Relationship of Dependents (check one)				
		Child	Step-Child	Guardian	Adult/Senior	Not Related

EMPLOYMENT SUMMARY

Patient	Spouse
Employer	Employer
Occupation	Occupation
Employment Status (check one)	Employment Status (check one)
☐ Full Time ☐ Part-Time ☐ Unemployed	☐ Full Time ☐ Part-Time ☐ Unemployed
☐ Housewife ☐ Unable to return to work	☐ Housewife ☐ Unable to return to work

HOUSEHOLD INCOME PER MONTH		HOUSEHOLD EXPENSES PER MONTH	
Patient	$ /mo.	Housing: ____ Own/Loan ____ Rent	
Spouse	$ /mo.	House Payment	$ /mo.
Alimony	$ /mo.	Utilities (electric, water)	$ /mo.
Unemployment	$ /mo.	Car # 1	$ /mo.
Child Support	$ /mo.	Car # 2	$ /mo.
Survivors Benefit	$ /mo.	Gasoline	$ /mo.
Workers Comp	$ /mo.	Insurance	$ /mo.
Trust Fund	$ /mo.	TV/ Cable / Phone	$ /mo.
Other	$ /mo.	Food	$ /mo.
TOTAL INCOME	$ /mo.	**TOTAL EXPENSES**	$ /mo.

BANK ACCOUNTS/OTHER ASSETS (must answer all 3 questions):

Checking Account? (circle one)	Yes	No	Current Balance	$
Savings Account? (circle one)	Yes	No	Current Balance	$
Additional Property? (circle	Yes	No	Current Value	$

If Yes, please describe: _____

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MEMORIAL HERMANN Surgical Hospital Kingwood

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FINANCIAL INFORMATION FORM / FINANCIAL ASSISTANCE APPLICATION

Patient Name:

* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

* The information I provided reflects HOUSEHOLD income and expenses.

* This information as well as a credit report and other publicly available information may be used by Memorial Hermann to establish a payment plan and/or to initiate an application for financial assistance and/or to determine eligibility for various programs, coverage or assistance.

* I give my consent to Memorial Hermann to obtain information from any source to verify the statements I have made.

* You will receive written communication from Memorial Hermann if the information provided is incomplete or insufficient to determine your eligibility for financial assistance or if you do not meet the eligibility qualifications. You will also be notified in writing if you are eligible for financial assistance.

* Patients who apply for financial assistance may be eligible for funds from local, state, or federal programs. Patients are expected to apply for such programs before a determination of eligibility for financial assistance. Memorial Hermann will provide assistance to individuals in applying for such programs. If a patient refuses to apply for, or follow through with an application for Medicaid or other coverage, the patients Financial Assistance Application will be denied.

* I affirm to the fact that I have applied for all possible insurance coverage, including Medicaid, Crime Victims, Health Exchange Insurance and any other local, state or federal coverage.

* I understand that if I do not qualify for financial assistance, I will be responsible for the cost of the care.

Patient/Guarantor Signature _____ Date _____

After completing this application, mail it and ALL supporting documents to:

Patient Business Services
300 Kingwood Medical Drive
Kingwood, TX 77339
Attention: Financial Assistance

Office Use Only
Financial Assistance Approved by Facility CEO / CFO

Approved by: _____ _____
Name / Signature Title Date

708887

MEMORIAL HERMANN
Surgical Hospital
Kingwood

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MEMORIAL HERMANN
Surgical Hospital
Kingwood

Dear Valued Patient:

Welcome to Memorial Hermann Surgical Hospital Kingwood. Our mission is to care for every patient and their family as if they were our own. Each patient, each family, each and every time.

In this packet you will find a copy of the following documents: On the right side of packet is paperwork to be completed for pre-registration. On the left side of the packet you will find HIPAA Privacy Notice, Patient Rights and Responsibilities, Patient Grievance and Advance Directive information (if you choose to enact an advance directive).

PRE-OPERATIVE ASSESSMENT – Prior to surgery you will need a pre-operative assessment completed by one of our nurses, which is intended to ensure that you receive high-quality care specific to your individual case. This may be done via a phone call or you may need to come to the hospital to have this assessment completed in person. Your assessment method is based on the type of procedure, your age and presence of pre-existing medical conditions. The hospital will inform you of the assessment method required in your particular case. You may call **(281) 312-4130** to inquire about your assessment or to schedule an appointment for your in-person assessment, if required. If you receive a voice recording, please leave a message and a nurse will return your call within 24 hours.

FINANCIAL – You will be receiving a call from a financial counselor prior to your procedure to discuss the payment that may be due on day of surgery. Registration is open from 6am to 5pm, and is available if you would like to pre-register for your procedure, which will reduce wait time on the day of your surgery. You may also call **(281) 312-4068** to inquire about your financial responsibilities.

DAY OF SURGERY – Mindy is your patient liaison, she is here to help you and your family before, during and after your procedure. She can be reached by dialing extension 4114 from any phone throughout the lobby or hospital.

If you have any concerns or comments, please allow us to resolve them immediately. We depend on our patients and their families to give us feedback regarding their visit at our facility. We strive to be an exemplary care provider with exemplary service. We encourage feedback and appreciate any comments you have about the service we provide at our hospital. You may receive a survey in the mail or via Email. As we strive to reach the highest ratings in every department, your comments and input are highly valuable.

Please contact the following services directly for questions about billing:
Anesthesia: (972)715-5080/(888)325-6084
Radiologist: (713)426-9121
Pathologist: (713)481-3557 or (281) 440-2829

Our hospital meets the Federal definition of a physician-owned hospital and a list of the hospital's owners that are physicians (or their immediate family members) is available upon your request.

We would also like to inform you that this facility does not provide 24/7 physician coverage in-house. There is a physician on call 24/7. In case of an emergency that exceeds the capability of this facility, you may be transferred to a local acute care hospital.

Thank you for choosing Memorial Hermann Surgical Hospital Kingwood!

Melinda Eller, BSN, MSN
Chief Executive Officer
281-312-4000

MEMORIAL HERMANN
Surgical Hospital
Kingwood

Our Mission Statement

Our mission is to care for every patient and their family as if they were our own. Each patient, each family, each and every time.

We keep the temperature cool in our hospital. We recommend that on the day of your procedure you and your family/friends bring a light jacket for your comfort.

Thank you for choosing Memorial Hermann Surgical Hospital Kingwood.
If you need anything while you are here, please ask our front desk staff or contact our patient liaison at 281-312-4114.

300 Kingwood Medical Drive Kingwood, Texas 77339 P 281.312.4000 F 281.358.2461 memorialhermannkingwood.org

MEMORIAL HERMANN
Surgical Hospital
Kingwood

Physician Ownership Disclosure

Memorial Hermann Surgical Hospital Kingwood is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies of our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Memorial Hermann Specialty Hospital Kingwood is partly owned by physicians and meets the federal definition of a "physician owned hospital" in 42 C.F.R. 489.3. Memorial Hermann Specialty Hospital Kingwood maintains a list of all its physician owners and this list is available to you upon request. Your physician may have a financial interest in this facility.

This information is being provided to you to help you make an informed decision about your healthcare. You have the right to choose your own healthcare provider. You have the option of obtaining healthcare ordered by your physician at a different facility, other than Memorial Hermann Specialty Hospital Kingwood. You will be treated no differently by Memorial Hermann Specialty Hospital Kingwood if you choose to use a different facility. If desired, the physician can provide information on different providers.

If you have any questions concerning this notice, please feel free to contact your physician or Memorial Hermann Specialty Hospital Kingwood at 281-312-4000.

Memorial Hermann Surgical
Hospital Kingwood
300 Kingwood Medical
Kingwood, TX 77339
(281)312-4000

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, and respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions including refusal of treatment or not following the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, eating and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing care givers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition, or any other patient health matters.

- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeit of care at the facility.
- Promptly fulfilling his or her financial obligations to the facility.
- Identifying any patient safety concerns.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility CEO- Melinda Eller by phone at (281) 312-4000 or by mail at:

Memorial Hermann Surgical
Hospital Kingwood
300 Kingwood Medical Dr.
Kingwood, TX 77339

Complaints and grievances may also be filed through:
Health Department
Health Facility Compliance
1000 W. 49th St.
Austin, TX 78756-3199
(512) 834-6650

OR

State of Texas, CMS Regional Office
DHHS/CMS/DMSO, CLIA Program
1301 Young Street, Room 833
Dallas, TX 75202
(214) 767-6301

Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protections by visiting the website for the Office of the Medicare Beneficiary Ombudsman at:
www.cms.hhs.gov/center/ombudsman.asp.

ADVANCE DIRECTIVE NOTIFICATION

In the State of Texas, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Memorial Hermann Surgical Hospital Kingwood respects and upholds those rights.
However, unlike in an acute care hospital setting, Memorial Hermann Surgical Hospital Kingwood does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

DISCLOSURE OF OWNERSHIP

Memorial Hermann Surgical Hospital Kingwood is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies of our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Your physician may have a financial interest in this facility.

United Surgical Partners
INTERNATIONAL

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.

Who Presents this Notice

The references to "Facility" and "Health Professionals" in this notice refer to the members of the United Surgical Partners International Affiliated Covered Entity. An Affiliated Covered Entity (ACE) is a group of organizations under common ownership or control who designate themselves as a single Affiliated Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Facility, its employees, workforce members and members of the ACE who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy Practices ("Notice"). The members of the ACE will share PHI with each other for the treatment, payment and health care operations of the ACE and as permitted by HIPAA and this Notice. For a complete list of the members of the ACE, please contact the Privacy & Security Compliance Office.

Privacy Obligations

Each Facility is required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Facility uses computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Facility uses or discloses your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Notifications

The Facility is required by law to protect the privacy of your medical information, distribute this Notice of Privacy Practices to you, and follow the terms of this Notice. The Facility is also required to notify you if there is a breach or impermissible access, use or disclosure of your medical information.

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Facility and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be

of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Privacy & Security Compliance Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Facility and Health Professionals.

Additionally, your PHI may be used or disclosed for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in a clinical Practicum.

Health Information Organizations. Your PHI may be used and disclosed with other health care providers or other health care entities for treatment, payment and health care operations purposes, as permitted by law, through a Health Information Organization. A list of Health Information Organizations in which this facility participates may be obtained upon request or found on our website at www.uspi.com. For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your medical information from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to registration.

Use or Disclosure for Directory of Individuals in the Facility. Facility may include your name, location in the Facility, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the

Facility and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Facility and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

U.S. Military. Your PHI may be use or disclosed to U. S. Military Commanders for assuring proper execution of the military mission. Military command authorities receiving protected health information are not covered entities subject to the HIPAA Privacy Rule, but they are subject to the Privacy Act of 1974 and DoD 5400.11-R , "DoD Privacy Program," May 14, 2007.

Other Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. Department of State under certain circumstances for example the Secret Service or NSA to protect the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Facility and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Facility and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Facility and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Facility and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Facility and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Facility; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s),

including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Facility and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Facility and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Health Information Management Office and submit the completed form to the Health Information Management Office. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Facility and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Facility Health Information Management Office identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Facility and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. Your request will be accommodated unless the Facility and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Privacy & Security

Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy & Security Compliance Office will provide you with the correct address for the Director. The Facility and Health Professionals will not retaliate against you if you file a complaint with the Privacy & Security Compliance Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on March 1, 2021.

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Facility and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Facility and on our Internet site at *www.uspi.com*. You also may obtain any new notice by contacting the Privacy & Security Compliance Office.

FACILITY CONTACTS:

Privacy & Security Compliance Office
14201 Dallas Parkway
Dallas, Texas 75254
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL): 1-800-8-ETHICS

Stop the Spread of Germs

Help prevent the spread of respiratory diseases like COVID-19.

Stay at least 6 feet (about 2 arms' length) from other people.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash and wash your hands.

When in public, wear a mask over your nose and mouth.

Do not touch your eyes, nose, and mouth.

Clean and disinfect frequently touched objects and surfaces.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

CDC

cdc.gov/coronavirus

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Detenga la propagación de gérmenes

Ayude a prevenir la transmisión de enfermedades respiratorias como el COVID-19.

Mantenga al menos 6 pies (aproximadamente la longitud de 2 brazos) de distancia de otras personas.

Cúbrase con un pañuelo desechable la nariz y la boca al toser o estornudar, luego bótelo en la basura y lávese las manos.

Cuando esté en un lugar público, use una mascarilla que cubra su nariz y boca.

Evite tocarse los ojos, la nariz y la boca.

Limpie y desinfecte los objetos y superficies que se tocan con frecuencia.

Quédese en casa cuando esté enfermo, excepto para recibir atención médica.

Lávese las manos frecuentemente con agua y jabón por al menos 20 segundos.

DEPARTMENT OF HEALTH & HUMAN SERVICES USA
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