Women's Health Associates of Richardson

Carol B. Norton, M.D. / Jan S. Risden, M.D.

Name: _____ Today's Date: _____
(Last) (First) (Middle)

If you go by something other than your legal name, please indicate here: _____

Address: _____ Apt./Condo #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which number would like to be primary? _____ May we leave messages at this number? ☐Y ☐N

Preferred contact method: ☐ PHONE ☐EMAIL ☐TEXT

Email Address: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex: _____

Race_____ Ethnicity_____ Primary Language_____

Who are you seeing today? ☐ Dr. Carol B. Norton ☐ Dr. Jan S. Risden ☐ Cori Poovey, WHCNP

Insured (Name of Insurance Card Holder – Self, Spouse, Parent, etc.): _____

Insured's Date of Birth: _____ Insured's SS#: _____

Insured's Employer: _____Phone: _____

In case of an emergency notify: _____ Phone: _____

Relationship to patient: _____ Other Contact Phone: _____

Prescription Pharmacy Name:_____ Phone : _____

Pharmacy address or closest intersection: _____

How did you hear about our office? _____

If referred to our office, by whom? _____

Your current Primary Care or Family Physician: _____ Phone: _____

Do you have a living will or advance directive: ☐ Yes ☐ No

The following information must be provided at your appointment: insurance cards, Driver's License or picture ID, and a major credit card. This information is necessary in order for our office to process your insurance claims more efficiently.

REMINDER: *Appointments will be rescheduled* for the following reasons:

- If a patient is more than 15 minutes late for an appointment.
- If a patient is unable pay for the office visit.
- If children that need supervision from the staff (except for newborns) are brought to the appointment.
- Rescheduling may be necessary in order for our staff to manage the schedule and for the courtesy of patients.

Patient Signature: _____ Date: _____

399 W. Campbell Road, Suite 410 Richardson, TX 75080
Office: 972-238-7799 Fax: 972-238-7135 Email: info@obgyn-wha.com
www.obgyn-wha.com

Women's Health Associates
Carol B. Norton, M.D. / Jan S. Risden, M.D.

GENERAL CONSENT FOR TREATMENT

***The following is a general consent for treatment for any services rendered here in the office, i.e. pap smear, breast exam, pelvic. If your plan of treatment requires further procedures, you will be consented on those specific procedures.*

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment.***

"I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of the Physicians of Women's Health Associates, their assistants, or their designee as is necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by Women's Health Associates of Richardson.

--Texas Medical Association.

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Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Women's Health Associates of Richardson for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Women's Health Associates of Richardson to release any medical or incidental information that may be necessary for either medical care or in processing claims or applications for financial benefits.

Medicare/Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Women's Health Associates of Richardson, Dr. Carol Norton or Dr. Jan Risden.

A photocopy of these assignments shall be as valid as the original.

Print Patient Name Here: _____ Date of Birth: _____

Print Parent or Guardian Name Here: _____

Signature: _____ Date: _____

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FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

For those insurance plans in which we participate, your predetermined portion of charges set by your insurance plan ***is due at the time of service.*** For your convenience we will accept VISA, MasterCard, and Discover. **A credit card imprint will be kept on file and used to pay any outstanding charges that are more than 30 days overdue.** Your signature below authorizes use of your credit card for this purpose.

Your Insurance

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment at the time of service. If you have insurance coverage under a plan with which we do not have a prior agreement, payment in full will be expected at time of service. You will be given the paperwork necessary to assist in filing your own claim. **Additionally, we do not file secondary insurances. Any balance due after the primary insurance pays is your responsibility.**

We make every effort to follow the guidelines required by your insurance company. However, every contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect payment from your insurance company after 60 days, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

If your insurance coverage changes, it is your responsibility to notify our office at least 48 hours before your next appointment. Failure to do so may result in rescheduling of your appointment.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the custodial parent or guardian, for payment. We will not disclose any confidential information to the parent or guardian without written and verbal consent of the minor.

Missed Appointments

Please call us as early as possible if you know you will need to reschedule your appointment. **Please note: There will be a $25 or $50 fee charged for any appointment missed without prior 24 hour notification.**

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Signature of Co-responsible Party/Credit Card Guarantor

_____ _____

Print Name of Patient Here **Date of Birth**

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Women's Health Associates

Carol B. Norton, M.D. / Jan S. Risden, M.D.

Name_____ **Age**_____ **Last Period**_____
Reason for visit _____

Are you <u>currently</u> having problems with any of the following (please circle all that apply):

Skin:	*Acne*	*Mole*	*Bruising*	*Rash*	*If yes, where*: _____
Vision:	*Unaided*	*Glasses*	*Contacts*	*Lasik*	
Hearing:	*Aided*	*Unaided*	*Hearing deficit*		
Menopause:	*Hot Flashes*	*Moodiness*	*Night Sweats*	*Vaginal Dryness*	
Breast:	*Pain*	*Masses*	Do you do a self-breast exam every month?	*Yes*	*No* *Sometimes*
Heart:	*Palpitations*	*Chest pain*			
Lungs:	*Cough*	*Shortness of breath with light activity*			
GI:	*Constipation*	*Diarrhea*	*Nausea*	*Vomiting*	*Rectal Bleeding*
Urinary:	*Frequency*	*Urgency*	*Burning*	*Pain*	*Incontinence*
Vaginal:	*Itching*	*Burning*	*Discharge*	*Odor*	
Weight:	*Stable*	*Increased*	*Decreased*	Amount over the past year? _____*lbs*	
Psychiatric:	*PMS*	*Depression*	*Anxiety*	*Mood Swings*	*Insomnia*
Neurological:	*Headaches*	*Dizziness*			
Musculoskeletal:		*Joint Pain*	*Muscle Pain*	If yes, where? _____	

Menstrual History: *Hysterectomy* *Menopause*
If still having cycles: How many days apart? _____ How many days do they last?_____
Current Menstrual Problems: *Heavy bleeding* *Pain* *Clots* *Bleeding between periods*

Date of last pap smear: _____ *Normal* *Abnormal*

Date of last mammogram (if applicable): _____ **Where?** _____

Sexually Active: *Yes* *Not currently* *Never* Any concerns? *Pain* *Bleeding* *Dryness*
Sexual partners are: *Male* *Female* *Both*

Birth Control: *Not necessary* *None* *Condoms* *Pill/Patch/Ring* *Injection* *Tubal* *IUD* *Vasectomy* *Other* _____

Primary Care Provider or Family Physician: _____
May we exchange medical information with your PCP? *Yes* *No*

Obstetrical History:
Number of Pregnancies: _____ Number of Deliveries: _____
Number of living children: _____
Type of Delivery: C-Section – How many _____ Vaginal – How many _____ Largest baby: ___#___oz

Have you ever had any of the following (if yes, please specify the number of times):
Miscarriage: _____ Ectopic Pregnancy: _____ Termination: _____

Gynecological History
Please indicate if you have had any of the following procedures and the year performed.

Hysterectomy:	*__Abdominal* *__Vaginal* *__Ovaries also removed*	Year_____
Laparoscopy for:	*__Ovary* *__Pelvic Pain* *__Endometriosis* *__Other*	Year_____
Tubal Ligation:	*__Laparoscopic* *__ Hysteroscopic* *__Post Partum*	Year_____
Breast:	*__Implants* (*under* or *over* muscle) *__Reduction* *__Biospy*	Year_____

Uterus/Cervix: __*LEEP* __*Cervical Cone* __*Cryotherapy (freezing)* __*D&C* Year_____
Other gynecological procedures (please list):
_____
_____

Have you ever had an abnormal pap smear? *No* *Yes*
Year of abnormal pap?_____
Treatment: __*Repeat pap* __*Colposcopy / biopsy* __*Cryotherapy* __*LEEP / Cone* __*Other*

How old were you when you had your first period? _____
If menopausal, at what age did you have your last period? _____
List methods of birth control or hormone replacement therapy you have used in the past:
_____
Total number of *male* sexual partners in your life: *0* *1-4* *5-10* *11-20* *>20*

INFECTIONS**:** Do you currently have or do you have a history of the following (please indicate year)
____*Chlamydia* ____*Gonorrhea* ____*Warts* ____*HPV* ____*Trichomonas* ____*Syphilis*
____*Herpes* (number of outbreaks per year? ____)

Any history of physical or sexual abuse / assault or concerns in your current relationship? *Yes* *No*

Past Medical History: (Hypertension, Diabetes, Asthma, Injuries, Blood transfusion, etc.)

Diagnosis	**Date**	**Treating MD**
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Non-Gynecological Surgeries: (Colonoscopy, Gallbladder, Appendix, etc)

Surgery	**Date**	**Diagnosis**
	/ /	
	/ /	
	/ /	
	/ /	

Immunizations (indicate the date)
Tetanus _____ Hepatitis B _____ HPV(Gardasil) _____

Drug Allergies: (Sulfa, Penicillin, Myacins, etc)

Drug	**Reaction (Itching, Shortness of Breath, Hives, etc)**

Are you allergic to any of the following: Iodine/ IV dye Peanuts Latex

Current Medications:

Medication	Date	Dosage Instructions	Diagnosis
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

Vitamins: *None Calcium Multivitamin Vit B Vit C Vit E Vit A Iron Others*:_____
Over-the-counter medications: _____
Herbal / Natural Supplements: _____

Social History:
Occupation: _____
Education (circle or complete): *High School College Graduate school Other*_____
Marital Status: *Single Engaged Married Widowed Separated Divorced Significant Other*
Live with: *Alone Roommate Family Spouse Fiancé Significant Other*
Type of Diet: *Regular Low Fat / Carbohydrate / Cholesterol Diabetic Vegetarian Other*
Exercise: *No Yes*
Type: *Cardio Weights Other* _____ # of days/week _____
Smoke: *No Yes* _____pack(s) per day for _____ years
Past Smoker: *No Yes* _____pack(s) per day for _____ years. Year quit _____
Alcohol: *No Yes* _____servings every: *day week month year*
Caffeine: *No Yes* Number of servings per day: _____
Drug Use: *No Yes* Type and frequency: _____
Do you have a living will (advanced directive)? *Yes No*

Family History:
Mother: *Alive Deceased* (from_____)
Father: *Alive Deceased* (from_____)

Condition:	Maternal/Paternal		Family Member
Breast Cancer	M	P	_____
Uterine Cancer	M	P	_____
Ovarian Cancer	M	P	_____
Colon Cancer	M	P	_____
Osteoporosis	M	P	_____
Blood Clot/DVT	M	P	_____
Heart Attack	M	P	_____
High Blood Pressure	M	P	_____
High Cholesterol	M	P	_____
Stroke	M	P	_____
Diabetes	M	P	_____
Thyroid Disorder	M	P	_____
Depression	M	P	_____
Congenital/Birth Defects	M	P	_____

Other_____

Preventative	Date	Ordering Physician
Blood Work		
Bone Density		

If a screening test is ordered and returns to us as "abnormal", further testing may be done and will likely be applied to your insurance deductible. This includes testing ordered at "Annual" or Well Woman exams.

We routinely check for Chlamydia with the Pap smear if you are 25 or younger per the American College of Obstetricians and Gynecologists (ACOG) recommendations.

We routinely check for Human Papilloma Virus (HPV) with the Pap smear if you are 30 or older at least every 3 years per ACOG and American Cancer Society recommendations. *This test may be applied to your insurance deductible.*

If you do not want HPV testing, check here: _____

Are you interested in screening for sexually transmitted diseases? (You will want to check insurance coverage before blood is drawn) _____ *Yes* _____ *No*

Do you have a preference on where you have lab work drawn? *Yes* *No* *Determine by my insurance*
If yes, which one? *LabCorp* *Quest*

Signature: _____ Date: _____

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Women's Health Associates of Richardson
Obstetrics and Gynecology

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your Individually Identifiable Health Information (IIHI). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice is effective **as of August 19, 2013** and will remain in effect until we replace it.

All of the employees of Women's Health Associates of Richardson have read and signed a ***Confidentiality Statement***. This document requires all employees who have access to Individually Identifiable Health Information (IIHI) to maintain all IIHI in a confidential manner as directed by law and by the Privacy Policies of this practice.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to patients upon request.

Right to a Paper Copy of this Notice

You may request a paper copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this Notice. You may obtain a copy of this notice on our website, www.wharichardson.com.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you (IIHI). Except for the purposes described below, we will use and disclose IIHI only with your written permission. You may revoke such permission at any time by writing to our Privacy Office.

Treatment: We are permitted to use and disclose your medical information to those involved in your treatment. For example, we may disclose IIHI to doctors, nurses, technicians, or other personnel, including people outside of our office, who are involved in your medical care and need the information to provide you with medical care.

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

Health Care Operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Individuals Involved in Your Care or Payment for Your Care:
Unless you object, we may disclose to your spouse, a member of your family, a relative, a close friend, or anyone else you identify, your IIHI that directly relates to that person's involvement in your health care. For example, making appointments for you, making calls to the office on your behalf, or being present in the exam room with the physician. We may use or disclose IIHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose

your IIHI to an authorized public or private entity to assist in disaster relief efforts and the coordinate uses and disclosures to family or other individuals involved in your health care.

You may list the person or persons whom you designate your authorization for Women's Health Associates of Richardson to communicate with, without additional forms to be completed. You may amend this list at any time in writing by contacting the person listed at the end of this Notice. You may list the person or persons authorized to receive and disclose IIHI on your behalf on the ***Acknowledgment of Review of Notice of Privacy Practices***.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services:
We may use and disclose IIHI to contact you to remind you that you have an appointment with us. We may also use and disclose IIHI to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

DISCLOSURE THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION
There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization. We will disclose IIHI when required to do so by international, federal, state or local law.

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

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, report this information to the state. HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

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

Business Associates: We may disclose IIHI to our Business Associates in order to provide services to our patients if the information is necessary for such functions or services. For example, we may use another company to perform billing services on your behalf. For this reason, we have required Business Associates to sign a ***Business Associate Agreement*** acknowledging and agreeing to follow all of the Privacy Practices of Women's Health Associates of Richardson as required by federal and state law.

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

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

The information is released pursuant to legal process, such as a warrant or subpoena;
The information pertains to a victim of crime and you are incapacitated;
The information pertains to a person who has died under circumstances that may be related to criminal conduct;
The information is about a victim of crime and we are unable to obtain the person's agreement;

The information is released because of a crime that has occurred on these premises; or
The information is released to locate a fugitive, missing person, or suspect.

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

Data Breach Notification Purposes:
We may use or disclose your IIHI to provide legally required notices of unauthorized access to or disclosure of your medical information.

Disaster Relief: We may disclose your IIHI to disaster relief organizations that seek your IIHI to coordinate your care, or notify your family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such disclosure whenever we can practically do so.

Workers' Compensation: We may disclose your medical information as required by workers' compensation law.

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

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

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors: When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law: We may release your medical information when law requires the disclosure.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
The following uses and disclosures of your IIHI will be made only with your written authorization, unless otherwise permitted or required by law:

1. Uses and disclosures of IIHI for marketing purposes; and
2. Uses and disclosures that constitute a sale of your IIHI; and
3. Uses and disclosures of psychotherapy notes, if applicable; and
4. Uses and disclosures of IIHI for fundraising purposes; and
5. For out-of-pocket payments: If you paid out-of-pocket (in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your IIHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, we will honor that request; and

Other uses and disclosure of IIHI not covered by this Notice or the laws that apply to us will be made only with your written authorization, unless otherwise permitted or required by law. If you do give us an authorization, you may revoke it any time by submitting a written revocation to our Privacy Officer and we will no longer disclose IIHI under the authorization. You will be asked to sign a ***Request, Disclosure and Authorization Form*** for disclosure of your IIHI.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.
You have the opportunity to agree or object to the use or disclosure of all or part of your IIHI. If you are not present or able to agree or object to the use or disclosure of the IIHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the individually identifiable health information that is relevant to your health care will be disclosed.

YOUR RIGHTS UNDER FEDERAL LAW

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

You have the right to inspect and copy your Individually Identifiable Health Information. This means you may request inspection or copying of your IIHI for as long as we maintain the IIHI. This includes medical and billing records, other than psychotherapy notes. Texas Law requires that requests for copies be made in writing, and we ask that your request for inspection of your health information also be made in writing. To inspect your IIHI, you will be asked to sign a ***Request, Disclosure and Authorization of Medical Records Form***. Our practice will accommodate *reasonable* requests.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

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

1. The information is psychotherapy notes.
2. The information reveals the identity of a person who provided information under a promise of confidentiality.
3. The information has been compiled in anticipation of litigation.
4. The information is subject to the Clinical Laboratory Improvements Amendments of 1988.

We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Texas law requires us to be ready to provide copies within fifteen (15) days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. Texas HB300, effective September 1, 2012, mandates physicians who use Electronic Health Records (EHR's) provide requested patient records in an electronic format within 15 business days of receiving a written request, unless there is an allowable exception.

HIPAA permits us to charge a reasonable cost-based fee. A fee of $25 (or more, depending in the number of pages and copies) may be charged, depending on the size of your records. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

Right to an Electronic Copy of Medical Records: If your IIHI is maintained in an electronic format (known as an electric medical record or electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your IIHI in the format you request, if it is readily reproducible in such form or format. If your IIHI is not readily reproducible in such form or format you request, your record will be provided in either our standard electronic format or a readable hard copy. We may charge a reasonable, cost based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured IIHI.

Right to Request Restrictions: You may request that we restrict or limit how your individually identifiable health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this

restriction, but if we do agree, we will comply with your request except under emergency circumstances. You may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

A ***Restriction of Personal Health Information Form*** can be furnished to you so that you can request whom you do not want your IIHI disclosed to. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom (the name/s, parties, etc.) the restrictions apply. Please send the request to the address and person listed at the end of this document. Forms are also available for ***Acceptance/Denial of Requested Restriction*** and ***Termination of Patient Restriction***.

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

Right to Amendment of Medical Information: If you feel the IIHI we have is incorrect or incomplete, you may ask us to amend to amend the information. You may request an amendment of your medical information in the designated record set by filling out a ***Patient Request for Amendment of Individually Identifiable Health Information Form*** and have it sent to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

The information wasn't created by this practice or the physicians in this practice.
The information is not part of the designated record set.
The information is not available for inspection because of an appropriate denial.
The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing by completing an ***Acceptance/Denial of Requested Amendment Form***.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the correct information. The ***Acceptance/Denial of Requested Amendment Form*** will be used in these situations as well.

Right to an Accounting of Certain Disclosures: HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. A ***Disclosure Accountability Request Form*** is available for this purpose. Our office will have this information for the patient no later than sixty (60) business days from the date of the request. Your first accounting of disclosure (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice on our website, www.wharichardson.com.

COMPLAINTS
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. ***A Patient Privacy Complaint Form*** is available for you for this purpose. We will not retaliate against you for filing a complaint with the government or us.

For more information about HIPAA, or to file a complaint with the Office of Civil Rights for complaints involving covered entities located in Arkansas, Louisiana, New Mexico, Oklahoma or Texas:

Region VI, Office of Civil Rights
U. S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone: (800)368-1019
Fax: (214)767-0432
TDD: (800)537-7697

OUR PROMISE TO YOU
We are required by law and regulation to protect the privacy of your medical information, to provide you with this Notice of our Privacy Practices with respect to Individually Identifiable Health Information, and to abide by the terms of the Notice of Privacy Practices in effect.

QUESTIONS AND CONTACT PERSON FOR REQUESTS
If you have any questions or want to make a request pursuant to the rights described above, please contact:

Shannon Ivy
Office Manager and Compliance Officer
Women's Health Associates of Richardson
Website: www.wharichardson.com
972-238-7799

A copy of this Notice of Privacy Practices is also available on our website at www.wharichardson.com

Updated 8/2013

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
AND REVIEW OF
PATIENT RESTRICTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I have received and reviewed Women's Health Associates of Richardson's' **Notice of Privacy Practices**, which explains how my Individually Identifiable Health Information (IIHI) may be used or disclosed. IIHI is the same as my medical information. I have also received a copy of this **Acknowledgment of Review and Patient Restriction of Protected Health Information**. I can fill in the names of friends, relatives, spouse, immediate family, etc. below if I want them to be able to have access to my IIHI. I understand that my Primary Care Physician will be provided access to my IIHI unless otherwise noted below.

I am confirming receipt of this Acknowledgment of Review of Privacy Practices and identifying who has access to my IIHI, other than myself. Please check below.

☐ I do not want anyone to have access to my IIHI. I am the only one who should have access to my IIHI.

☐ It is agreed and acceptable for my "spouse only" to have access to my IIHI.

☐ Patient is under eighteen (18) years of age and understands that his/her legal representative has access to his/her IIHI and the legal representative is signing below.

☐ I want the person/s listed below to have access to my IIHI:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do not want my Primary Care Provider to have access to my IIHI.

☐ It is acceptable to leave a detailed, medical phone message for me at the following number:

(_____) _____ ☐ Home ☐ Work ☐ Cell

_____
Printed Name of Patient

_____
Signature of Patient **IF NOT A MINOR**

_____
Signature of Personal/Legal Representative **IF PATIENT A MINOR**

_____
Personal/Legal Representative's Relationship to Patient

Date _____

Physician Signature _____

_____
Signature of Compliance Officer for Women's Health Associates of Richardson

Directions to Women's Health Associates of Richardson

Women's Health Associates of Richardson
Obstetrics & Gynecology
Carol B. Norton, M.D. / Jan S. Risden

399 W. Campbell Road, Medical Plaza II, Suite 410 Richardson, TX 75080
Phone: 972-238-7799 Fax: 972-238-7135

Women's Health Associates is located in Medical Plaza II (physician building located on the left side of Methodist Richardson Medical Center). Our office is on the 4th floor of Medical Plaza II, Suite 410.

Office Hours: Mon, 9 – 6: Tues - Thurs, 8 – 5: Fri 7 - noon

Turn in at the entrance of Methodist Richardson Medical Center. There is a light at the entrance at Canyon Creek Drive. When pulling in to the hospital, you will be forced to go the left or the right. Follow the drive to the left, past the Emergency Room. You will see Medical Plaza II ahead of you. You may park in front of Medical Plaza II (there is no charge for parking) or you may pull up to the front entrance of Medical Plaza II and have the valet park your car. There is no charge for valet parking for patients.

From the North

- **Go South on Central Expressway**
- **Take the Campbell Road Exit, turn right (West). Methodist Richardson Medical Center (hospital campus) will be on your immediate left after N. Collins Blvd. (approximately 5 blocks west of 75 Central Expressway. Medical Plaza II is on the left side of Methodist Richardson Medical Center**

From the South

- **Driving North on Central Expressway, exit Campbell Road, turn left (West).**
- **Methodist Richardson Medical Center (hospital campus) will be on your immediate left after N. Collins Blvd. (approximately 5 blocks west of 75 Central Expressway). Medical Plaza II is on the left side of Methodist Richardson Medical Center.**
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