Women's Health Associates

Carol B. Norton, 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.

--Texas Medical Association.

****

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Women's Health Associates 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 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, Dr. Carol Norton and Dr. Alisa Ward.

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: _____

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.

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**

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.

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 protected health information (PHI). 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 **April 14, 2003** and will remain in effect until we replace it.

All of the employees of Women's Health Associates (WHA) have read and signed a ***Confidentiality Statement***. This document requires all employees who have access to Protected Health Information (PHI) to maintain all PHI in a confidential manner as all PHI is protected by law and by the Privacy Policies of this practice.

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.

You may request a 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.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
Treatment: We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a Specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. You may elect to fill out a ***Patient Authorization for Personal Representative Form***, which provides for a person you name to have access to your protected health information. Unless this form is completed by the patient, Women's Health Associates will comply with the privacy practices in this Notice regarding your protected health information.

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 or HMO. This form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO 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.

Business Associates: In order to provide services to our patients, a Business Associate of ours may come into contact with patient and/or employee's PHI. For this reason, we have had any Business Associate sign a ***Business Associate Agreement*** acknowledging and agreeing to follow all of the Privacy Practices of Women's Health Associates and as required by federal and state law.

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.

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.

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.

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 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 protected health information.** This means you may request inspection or copying of your PHI for as long as we maintain the PHI. When requesting a copy of your PHI, you will be asked to sign a ***Request, Disclosure and Authorization of Medical Records Form***.

Other names for the ***Request, Disclosure and Authorization Form*** are: *Authorization for Use or Disclosure of Protected Health Information; Patient Authorization for Disclosure to Designated Provider; Provider Request for Disclosure from another Covered Entity; Request for Access to Protected Health Information.*

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. 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 will be asked to sign a ***Request, Disclosure and Authorization Form*** for disclosure of your PHI.

You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Health Care: Unless you object, we may disclose to a patient's spouse, member of your family, a relative, a close friend, or anyone else you identify, your PHI, that directly relates to that person's involvement in your health care (such as making appointments for the patient, making calls to the office on behalf of the patient, being present in the exam room with the physician, responsible for your care, your location, your general condition or death, etc.). Finally, we may use or disclose your PHI 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.

Unless you object, we may disclose to a member of your family, a relative, a close friend, or anyone else you identify, your PHI that directly relates to that person's involvement in your health care. We may use or disclose PHI 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 PHI 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 person/s whom you designate your authorization for Women's Health Associates to communicate with, without additional forms to be completed. This list can be amended at anytime in writing by the patient by contacting the person listed at the end of this Notice. You may list the person or persons authorized to receive and disclose PHI on your behalf on the ***Acknowledgment of Review of Notice of Privacy Practices***.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practical after the deliver of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Request Restrictions: You may request that we restrict or limit how your protected 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 PHI 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***.

Inspection and Copies of Protected Health Information: You may inspect and/or copy health information that is within the designated records set, which is information that is used to make decisions about your care. Texas law requires that copies be made in writing, and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

Receiving Confidential Communications by Alternate Means: You may request that we send communications of protected health information by alternative 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.

Inspection and Copies of Protected Health Information: You may inspect and/or copy health information that is within the designated records set, which is information that is used to make decisions about your care. 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. Please send your request to the person listed at the end of this document.

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:

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

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

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. A fee of $25 (or more, depending in the number of copies) may be charged, depending on the size of your records.

HIPAA permits us to charge a reasonable cost-based fee.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI as of April 14, 2003. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. A ***Disclosure Accountability Request Form*** is available for the Patient to fill out 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.

Amendment of Medical Information: You may request an amendment of your medical information in the designated record set by filling out a ***Patient Request for Amendment of Protected 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.

Accounting of Certain Disclosures: HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosure 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. 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.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER BENEFITS
We may contact you by telephone, mail, or email to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

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 IV, Office of Civil Rights
U. S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone: 214-767-4056 Fax: 214-767-0432
TDD: 214-767-8940

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 protected 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:

Practice Privacy Office
Office Manager and Compliance Officer
Women's Health Associates
399 W. Campbell Road, Medical Plaza II, Suite 410, Richardson, TX 75080
Voice Phone: (972) 238-7799 Fax: (972) 238-7135
Email: officemgr@obgyn-wha.com
Website: www.obgyn-wha.com
A copy of this Notice of Privacy Practices is also available on our website at www.obgyn-wha.com

Women's Health Associates
Carol B. Norton, M.D.

ACKNOWLEDGMENT OF REVIEW AND
PATIENT RESTRICTION OF PROTECTED HEALTH INFORMATION
NOTICE OF PRIVACY PRACTICES

I have received and reviewed Women's Health Associates' **Notice of Privacy Practices**, which explains how my personal health information (PHI) may be used or disclosed. PHI 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 name/s of friends, relatives, spouse, immediate family, etc. below if I want them to be able to have access to my PHI.

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

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

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

☐ It is agreed and acceptable for any of my immediate family members to have access to my PHI.

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

☐ I do not want anyone to have access to my PHI other than the person/s listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

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

_____
Printed Name of Patient

_____
Personal/Legal Representative's Relationship to Patient

_____
Date

☐ Carol B. Norton, M.D.

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

Directions to Women's Health Associates

Women's Health Associates

Obstetrics & Gynecology **Carol B. Norton, M.D.**

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.**