NICHOLSON CLINIC
For Weight Loss Surgery

Paperwork must be complete by your appointment time or your appointment may be rescheduled.

(PLEASE PRINT LEGIBLY, add as much detail as possible, and use BLACK OR DARK BLUE INK.)

PLEASE LIST YOUR FULL LEGAL NAME:

LAST:	**FIRST:**	**MIDDLE:**
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:

PLEASE ENTER YOUR CONTACT INFORMATION:			
1ST Choice Contact #	☐ Home ☐ Mobile ☐ Work	( ) -	
2ND Choice Contact #	☐ Home ☐ Mobile ☐ Work	( ) -	
3RD Choice Contact #	☐ Home ☐ Mobile ☐ Work	( ) -	
EMAIL:			
EMERGENCY CONTACT NAME:	RELATIONSHIP:	PHONE#: ( ) -	
My emergency contact may receive information about my medical conditions. ☐Yes ☐ No			
SSN: - -	DOB: / /	AGE:	GENDER: ☐ F ☐ M
MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other_____			
ETHNICITY: ☐ Hispanic/Latino Origin ☐ Non-Hispanic/Non-Latino Origin			
RACE: ☐Asian ☐ Black ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ White ☐Other _____			
EMPLOYER:	OCCUPATION:		
PRIMARY CARE PHYSICIAN:	PHONE#: ( ) -		
REFERRING DOCTOR:	PHONE#: ( ) -		
ADDRESS:			
My physician(s) may receive information regarding my surgery. ☐ **Yes** ☐ **No**			

TELL US HOW YOU HEARD ABOUT OUR PRACTICE

☐ Internet/Nicholson Clinic Website ☐ PCP/Referring Doctor ☐ Friend/Family Member
☐ TV/Radio/Magazine Advertisement ☐ Insurance Company ☐ Billboard
☐ Current Patient, if so who?_____

****For patients who intend to self-pay, please note that in the box below and do not complete the insurance information. This will help to avoid delays in processing your application****

INSURANCE INFORMATION:

PRIMARY INSURANCE PLAN:		PLAN TYPE: ☐ HMO ☐ PPO ☐ POS	
ADDRESS:			
CITY:	STATE:	ZIP:	
ID#:	GROUP#:	PHONE#: ( ) -	
NAME OF INSURED:		INSURED'S DOB:	
RELATIONSHIP:		SSN (if other than patient):	
EMPLOYER NAME:			
SECONDARY INSURANCE PLAN:		PLAN TYPE: ☐ HMO ☐ PPO ☐ POS	
ADDRESS:			
CITY:	STATE:	ZIP:	
ID#:	GROUP#:	PHONE#: ( ) -	
NAME OF INSURED:		INSURED'S DOB:	
RELATIONSHIP:		SSN (if other than patient):	
EMPLOYER NAME:			

PATIENT NAME:	DOB:

HEALTH AND MEDICAL HISTORY (Complete as much as possible)

HEIGHT: CURRENT WEIGHT: BMI:

PLEASE ☑ THE SURGERY YOU ARE INTERESTED IN:

☐ Roux-en-Y Bypass ☐ Lap-Band™ ☐ Sleeve Gastrectomy ☐ Gastric Balloon ☐ Revision

PREVIOUS WEIGHT LOSS SURGERY:

(Please complete if you are seeking revision surgery)

☐ Sleeve Gastrectomy	Year:	☐ Lap-Band™	Year:
☐ Roux-en-Y Gastric Bypass	Year:	☐ Stomach Stapling Procedure / VBG	Year:
☐ Other			
Present complications due to previous weight loss surgery:			
Weight prior to previous weight loss surgery:			
Reason you are in need of a revision weight loss surgery:			

SURGICAL HISTORY:

(Please ☑ all that apply)

☐ Gallbladder Surgery	Year:	☐ Spleen Surgery	Year:
☐ Esophagus Surgery	Year:	☐ Stomach Surgery	Year:
☐ Hernia Repair	Year:	☐ Caesarian Section	Year:
☐ Abdominal Hysterectomy	Year:		

MEDICALLY SUPERVISED TREATMENT REGIMENS:

(Please ☑ all that apply)

				To - From	
Fen-Phen	☐ Yes	☐ No	Year:	-	Physician:
Phentermine	☐ Yes	☐ No	Year:	-	Physician:
Redux	☐ Yes	☐ No	Year:	-	Physician:
Other:_____	☐ Yes	☐ No	Year:	-	Physician:

OTHER WEIGHT LOSS METHODS:

(Please ☑ all that apply)

		To - From			To - From
☐ Weight Watchers	Year:	-	☐ Herbalife	Year:	-
☐ Slim Fast	Year:	-	☐ Advocare	Year:	-
☐ Medifast	Year:	-	☐ Jenny Craig	Year:	-
☐ Nutrisystem	Year:	-	☐ South Beach	Year:	-
☐ Atkins Diet	Year:	-	☐ Metabolife	Year:	-
☐ Other:					
Maximum weight lost on ANY program:					
Have you ever been treated for an eating disorder? ☐ Yes ☐ No					
If Yes, please describe treatment, duration, and year:_____					

PATIENT NAME:	DOB:

HEALTH AND WELLNESS INFORMATION

(Please ☑ all that apply)

Problem/Symptom	Y	N	Year	Diagnosing Physician	Problem/ Symptom	Y	N	Year	Diagnosing Physician
Shortness of Breath	☐	☐			Snoring	☐	☐		
Sleep Apnea Syndrome	☐	☐			CPAP	☐	☐		
Indigestion/Heartburn	☐	☐			BiPAP	☐	☐		
Gastroesophageal Reflux	☐	☐			Asthma	☐	☐		
Congestive Heart Failure	☐	☐			Stroke	☐	☐		
Pulmonary Embolism	☐	☐			Hernia	☐	☐		
COPD/Emphysema	☐	☐			Infertility	☐	☐		
Migraine Headaches	☐	☐			Anorexia	☐	☐		
Irregular Menstruation	☐	☐			Bulimia	☐	☐		
Bipolar Disorder	☐	☐			Chest Pain	☐	☐		
Schizophrenia	☐	☐			Colitis	☐	☐		
Chronic Fatigue	☐	☐			Cirrhosis	☐	☐		
Fibrocystic Breast Disease	☐	☐			Hepatitis B	☐	☐		
Urinary Incontinence	☐	☐			Hepatitis C	☐	☐		
Crohn's Disease	☐	☐			Depression	☐	☐		
High Cholesterol	☐	☐			Heart Attack	☐	☐		
Degenerative Joint	☐	☐			Heart Disease	☐	☐		
Hyperlipidemia	☐	☐			Panic Disorder	☐	☐		
Ulcerative Colitis	☐	☐			Edema/Swelling	☐	☐		
Diabetes	☐	☐			☐ Legs ☐ Ankles				
☐ Self ☐ Family					Disease/Pain	☐	☐		
Hypertension	☐	☐			☐ Hips ☐ Ankles ☐ Knees ☐Lower Back				
☐ Self ☐ Family					Blood Clots	☐	☐		

Do you currently smoke/vape?	☐ Yes ☐ No	Have you ever smoked/vaped?	☐ Yes ☐ No	Year Quit:
Do you use alcohol? ☐ Yes ☐ No	How often?	☐Daily	☐ Weekly	☐ Occasionally ☐ Rarely
Have you ever had a problem with substance abuse?	☐ Yes ☐ No			
Do you have a heart condition?	☐ Yes ☐ No	If Yes, Explain:		
Do you have any other underlying medical conditions?	☐ Yes ☐ No	If Yes, Explain:		

RECENT TESTING

Physical	☐ Yes	☐ No	DATE:	Upper GI	☐ Yes	☐ No	DATE:
Chest X-Ray	☐ Yes	☐ No	DATE:	EKG	☐ Yes	☐ No	DATE:
Echocardiogram	☐ Yes	☐ No	DATE:				

Indicate any negative results:

CURRENT PATIENT MEDICATIONS DATE:_____

NAME:_____ **DATE OF BIRTH:**_____ **MEDICATION ALLERGIES:**_____

PHARMACY NAME:_____ **PHARMACY PHONE:** _____

Do you take antacids? (please check allthat apply) **Date Started:**_____

☐ Maalox ☐ Mylanta ☐ Tums ☐ Rolaids ☐ Pepto-Bismol ☐ Pepcid (famotidine) ☐ Zantac (ranitidine) ☐ Tagamet (cimetidine) ☐Prilosec (omeprazole)

☐ Aciphex (rabeprazole) RX ☐ Nexium (esomeprazole) RX ☐ Prevacid (lansoprazole) RX ☐Protonix (pantoprazole)RX OTHER: _____

Vitamin/Mineral Supplements: (please check allthat apply): ☐Never ☐ Occasionally ☐Daily

☐ Multi Vitamin ☐ Vitamin D ☐ Vitamin B-12 (weekly) Other: _____

Do you have anemia? ☐ YES ☐NO **IRON** supplementation ☐YES ☐NO

Date Started:_____ **How often?** _____

Do you take OTC pain relievers? (please check all that apply): ☐ YES ☐ NO **Date Started**:_____

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Motrin, Advil) ☐ Naproxen (Aleve, Naprosyn) ☐Aspirin OTHER: _____

Tobacco: ☐Never ☐Rarely ☐Occasionally ☐Frequently Quit (Month/Year): **Alcohol:** ☐ Never ☐Rarely ☐Occasionally ☐Frequently

CPAP/BIPAP: ☐ Never ☐ Occasionally ☐ Every Night

MEDICATION NAME/STRENGTH	ROUTE	DOSE	PURPOSE	DATE STARTED	DATE STOPPED
EXAMPLE: SAMPLE 200mg	*By mouth*	*1xday*	*Blood Pressure*	*May 2009*	
OTHER OTC MEDICATIONS:					

REVIEWED BY MEDICAL STAFF DATE/INITIALS	

"S.T.O.P. – B.A.N.G." Sleep Apnea Questionnaire

Please complete this form to the best of your knowledge

1. Do you **SNORE** loudly?	☐ Yes	☐ No
2. Do you often feel **TIRED** during the daytime?	☐ Yes	☐ No
3. Has anyone ever **OBSERVED** you stop breathing while sleeping?	☐ Yes	☐ No
4. Do you have or are you being treated for high blood **PRESSURE**?	☐ Yes	☐ No
5. Is your **BMI** more than 35kg/m2?	☐ Yes	☐ No
6. **AGE** over 50?	☐ Yes	☐ No
7. **NECK** circumference greater than 17 inches (men)/ 16 in. (women):	☐ Yes	☐ No
8. **GENDER** male?	☐ Yes	☐ No

Symptoms of Sleep Disorders

PLEASE ☑ ALL THAT APPLY

- ☐ Insomnia or inability to sleep well
- ☐ Excessive daytime sleepiness / Napping
- ☐ Loud snoring
- ☐ Morning Headaches
- ☐ Uncomfortable sensations or jerking of the limbs
- ☐ Restless Sleep or "tossing and turning"
- ☐ Weight Gain/ Obesity
- ☐ Personality Changes
- ☐ Irregular breathing during sleep
- ☐ Loss of Energy/ Fatigue
- ☐ Lack of Concentration
- ☐ Confusion
- ☐ Leg Swelling
- ☐ Difficulty getting to sleep or staying asleep
- ☐ Vivid, frightening or violent dreams

PATIENT'S PRINTED NAME DATE OF BIRTH

PATIENT SIGNATURE OR RESPONSIBLE PARTY DATE

Heartburn/ Reflux Questionnaire

Instructions: please check the box to the right of each question using the scale below.

Scale

0 No symptoms
1 Symptoms noticeable but not bothersome
2 Symptoms noticeable and bothersome, infrequent
3 Symptoms bothersome every day
4 Symptoms affect daily activity
5 Symptoms interfere with daily activities

Question	1	2	3	4	5
How bad is your heartburn?					
Heartburn when lying down?					
Heartburn when standing up?					
Heartburn after meals?					
Does heartburn change your diet?					
Does heartburn wake you from sleep?					
Do you have difficulty swallowing?					
Do you have pain with swallowing?					
If you take medication, does this affect your daily life?					
How bad is the regurgitation?					
Regurgitation when lying down?					
Regurgitation when standing up?					
Regurgitation after meals?					
Does regurgitation change your diet?					
Does regurgitation wake you from sleep?					

Instructions: please answer the questions below by **circling** the appropriate response.

- How long have you been dealing with the symptoms above? 5 years 10 years 15+ years Other
- Have you tried medications to treat your symptoms in the past without relief? Yes No

Instructions: please indicate which medications you have attempted in the past by **checking** √ the duration of therapy.

Medication	5 yrs	10 yrs	15+ yrs	Other	Medication	5 yrs	10 yrs	15+ yrs	Other
Pepcid®					Aciphex®				
Famotidine					Rabeprazole				
Prilosec®					Prevacid®				
Omeprazole					Lansoprazole				
Dexilant®					Zegerid®				
Dexlansoprazole					Sodium Bicarb				
Protonix®					Tums®				
Pantoprazole					Rolaids®				
Zantac®					Pepto Bismol®				
Ranitidine					Other Medication				

PATIENT'S PRINTED NAME DATE OF BIRTH

PATIENT SIGNATURE OR RESPONSIBLE PARTY DATE

PRACTICE EXPECTATIONS/PATIENT AGREEMENT: (Please read carefully before signing)

APPOINTMENTS:

- If I am unable to keep my appointment, I will call to cancel with 24 hours advance notice so that another patient can be scheduled in my place.
- If I am more than 15 minutes late to my appointment, I may be asked to reschedule.

INSURANCE AND PAYMENT:

- If my insurance is being utilized for any services, payment will be expected for co-pays, deductibles or co-insurance amounts. This includes my initial consultation, surgical procedures or follow up office visits.
- I realize I am responsible for charges incurred for my care should my insurer fail to reimburse in an acceptable and timely manner.

Please note that all medical providers must submit separate bills for their services. You and your insurance company may be billed for services from various providers during your course of treatment. Nicholson Clinic cannot always tell which services you will need but we want you to be aware that you may receive bills from any of the following:

Surgeon / assistant surgeon	anesthesiologist	radiologist
Hospital / surgical facility	pathologist	laboratory

Other providers while at hospital: internist, hospitalist, cardiologist, pulmonologist, or other specialist

Nicholson Clinic does not have control over other provider's billing practices nor do we have the ability to have other providers forgive your financial responsibilities with them. Please contact each provider directly should you have questions about their bills.

REFERRING PROVIDERS AND FACILITIES:

We may make referrals to medical providers that may be out of network with your insurance plan because we believe them to be quality providers. As a standard of this office, we may refer to Baylor Scott and White Medical Center - Plano, Baylor Surgicare at Garland, Medical City Frisco, Diez Services Anesthesia, Clinical Pathology Labs (CPL), Quest Diagnostics and SLIIIP. The surgeons associated with this practice may or may not have a personal investment in these or other healthcare facilities. You are invited to discuss this with us or our office staff if you desire.

Nick Nicholson, MD Thomas Roshek, MD Brian Long, MD

SELF PAY – REQUEST FOR RESTRICTION ON DISCLOSURES

- By signing below, I acknowledge that I may choose to pay out-of-pocket ("self-pay") for one or more medical services or procedures provided by Nicholson Clinic.
- Unless I explicitly request otherwise in writing, I do **not** authorize the Nicholson Clinic to submit any related information, claims, or documentation regarding these self-paid services to my health insurance company or any third-party payor.
- By signing below, I affirm that I am exercising my right to request a restriction on the disclosure of protected health information for self-paid services, and I understand the implications of this choice.

Please note that this request applies only to the services or procedures for which you chose to pay for out-of-pocket ("self-pay"). Your insurance company may not reimburse you for any self-paid procedures. Our office will make a good faith effort to restrict disclosure of your self-pay services as requested, in accordance with HIPAA regulations (45 CFR § 164.522(a)).

By signing below, I confirm that the information provided is accurate to the best of my knowledge. I acknowledge that I have read, understood, agreed to, and authorized the requests outlined above.

PATIENT'S PRINTED NAME DATE OF BIRTH

PATIENT SIGNATURE OR RESPONSIBLE PARTY DATE

Email Informed Consent Form

Conditions for the Use of Email

It is the policy of Nicholson Clinic to make all email messages sent or received that concern the protected health information ("PHI"), a part of that patient's medical and financial records. Nicholson Clinic strives to protect and maintain patient PHI. However, there are numerous risks associated with email communication, which may include but not limited to misaddressed or undelivered emails, risk associated with use of employer owned email address, and/or delay in response time. Nicholson Clinic cannot fully guarantee the security and confidentiality of email communications. Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record, other individuals, such as other physicians, nurses, other entities, suchas other health care providers and insurers, may have access to email messages contained in medical records.
- Nicholson Clinic may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. However, emails to entities unassociated with the patient's care, will not be forwarded, unless proper patient consent is received,
- Nicholson Clinic and its employees will make every effort to read and respond promptly to patient emails. Because Nicholson Clinic**cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
- If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the emailand when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases; mental health or developmental disability; or alcohol and drug abuse.**
- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Nicholson Clinic will take reasonable steps to protect the confidentiality of patient email, but is not liable for improper disclosure of confidential information not caused by Nicholson Clinic gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Nicholson Clinic of any types of information that the patient does not want to be sent by email other than those set outabove.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Nicholson Clinic to protect confidentiality. Nicholson Clinic is not liable for breaches of confidentiality caused by patient.

Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the future use of email at any time by email or written communication to Nicholson Clinic, attention:

Denise C: HIPAA Compliance Officer
5000 Legacy Dr. #200
Plano, Tx 75024
Denise@Nicholsonclinic.com

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Nicholson Clinic regarding my medical treatment.

Signature of Patient	Email Address	Date
Printed Name of Patient	Date of Birth	

BAYLOR SCOTT & WHITE HEALTH
PERMISSION FOR VERBAL COMMUNICATION

Patient Name | Date of Birth | Phone Number(s)

Full Address (City, State, and Zip Code)

I permit Baylor Scott & White Health to discuss my personal medical-health information, in person and/or by telephone, with the following persons involved in my medical care for the following purposes:

- To orally schedule or confirm my appointments;
- To discuss my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; or
- To discuss billing and payment for medical services.

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

	Name	Relationship	Phone Number
1.			
2.			
3.			

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health - Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508.
This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here _____. This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

Signature of Patient or Legal Representative (electronic signatures not acceptable) | Date

Print Name of Patient or Legal Representative | Relationship to Patient

Representative's Authority to Act for Patient
(attach supporting documentation)

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.

Understanding Your Health Record/ Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This Notice of Privacy Practices ("Notice") describes the privacy practices of Baylor Scott & White Health ("BSWH") and its Affiliated Covered Entity ("BSWH ACE") members. An Affiliated Covered Entity ("ACE") is a group of Covered Entities, Health Care Providers and Health Plan under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the BSWH ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the BSWH ACE and as permitted by HIPAA and this Notice. As an ACE, BSWH may add or remove Covered Entities as part of the BSWH ACE. For a complete current list of the members of the BSWH ACE, please visit our website at www.BSWHealth.com/PrivacyMatters. The list will also be made available upon request either at our facilities or by contacting us toll-free at 1-866-218-6920.

This Notice will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your records

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you by:
  - Contacting the Health Information Management Department at the hospital or the outpatient clinic directly where you received care; or
  - Calling the Scott & White Health Plan ("SWHP") Customer Advocacy line at 254-298-3000 or toll-free at 1-800-321-7947 or writing to 1206 West Campus Drive, Temple, TX 76502, ATTN: Customer Advocacy, if you are a member of the health plan.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization:
  - Send written notice to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request an Amendment:
  - Send written notice to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- We will not ask you the reason for your request.
- You may request a confidential communication by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- You may request this restriction by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request a list of those with whom we've shared information:
  - Contact us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- You may also view a copy of this Notice on our BSWH and SWHP member websites.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your privacy rights have been violated

- You can complain if you feel we have violated your privacy rights by:
  - Contacting us toll-free at 1-866-218-6920, by visiting www.BSWHealth.com/PrivacyMatters or in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling toll-free at 1-877-696-6775,

or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- For questions or other complaints, you may also contact:
  - The outpatient clinic directly or the Patient Relations Department at the hospital where you received care toll-free at 1-866-218-6919.
- For questions or other complaints relating to Health Plan Coverage:
  - SWHP members contact the Customer Advocacy line at 254-298-3000 or toll-free at 1-800-321-7947.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In the following cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again by letting us know you wish to opt-out of any further fundraising communications.
- Information on how to opt-out will be included in any fundraising communications you may receive.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- We may use your health information to give you information about treatment alternatives or health related benefits/services that may be of interest to you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

- We can use and share your health information as necessary to operate and manage our business activities related to providing and managing your health care insurance.

Example: We might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

Communications regarding treatment alternatives and appointment reminders

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Bill for our services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for our services.

For payment

- We can use and share your health information for payment of premiums due to us, to determine your coverage, and for payment of health care services you receive.

Example: We might tell a doctor if you are eligible for coverage and what percentage of the bill might be covered.

For underwriting purposes

- We may use or share your health information for underwriting purposes; however, we will not use or share your genetic information for such purposes.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as the ways mentioned below. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Student immunizations to schools

- We may disclose proof of your child's immunizations to their school based on your verbal or written permission.

Do research

- We can use or share your information for health research.

Food and Drug Administration (FDA)

- We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address worker's compensation, law enforcement and other government requests

We can use or share health information about you:

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Electronic Health Information Exchange (HIE)

- We maintain electronic health information about you from other health care providers or entities that are not part of our healthcare system who have treated you or who are treating you and this information is also stored in the HIE.
- Our healthcare system and these other providers can use the HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law.
- We monitor who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers.
- You may opt-out of the HIE by providing a written request to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201. If you opt-out, your information will still be stored in the HIE, but your information will not be viewable through the HIE.
- You may opt back in to the HIE at any time.
- You do not have to participate in the HIE to receive care.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our BSWH and SWHP member websites.

Effective Date: December 2018

Signature of Patient or Legal Representative (electronic signatures not acceptable) _____ Date _____

Print Name of Patient or Legal Representative _____ Relationship to Patient _____

Representative's Authority to Act for Patient
(attach supporting documentation) _____