PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ (BEING SEEN TODAY)

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ (LAST / FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM DD YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Alt/Cell Phone: (___) _____ Day Phone: (___) _____ Email: _____

Race _____ Language _____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____

Emergency Contact: *(Please Indicate a friend or relative not living at the same address.)*

_____ (NAME) _____ (RELATIONSHIP) (___) _____ (EMERGENCY CONTACT #)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ___ Other _____ (SPECIFY) Resp. Party SS #: _____

Name: _____ (LAST / FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM DD YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____ (___) _____ (WORK PHONE) (___) (EXT)

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ (DATE OF BIRTH) Spouse's Work Phone: (___) _____ (___) (EXT) Occupation: _____

PRIMARY INSURANCE

Please complete the information below and provide a copy of the Insurance card.

Insurance Company: _____ Address: _____ (STREET or P.O. BOX) (___) _____ (PHONE)

Co-Pay Amount: (if applicable) _____ _____ (CITY) ___ (ST) _____ (ZIP)

Primary Care Physician: _____

Policy Holder: _____ (LAST / FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS #)

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____ (SPECIFY)

Employer's Name: _____ _____ (INSUREDS ID) _____ (GROUP NAME AND/OR NUMBER)

Address: _____ (STREET) _____ (CITY) ___ (ST) _____ (ZIP)

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

Darien W. Bradford, MD
515 W. Mayfield Rd. Suite 404
Arlington, TX 76014
Phone (817) 465-5311 Fax (817) 465-8569

Please fill in each blank as accurately as possible so that your health can be fully evaluated.

Patient Name: _____ DOB: _____

Email or Wireless cell phone provider:
_____

ALLERGIES:

Medication Name/Dosage	Frequency	Date Started

Please list any personal medical history including surgeries, hospitalizations and diseases with the year of occurrence:

_____
_____
_____
_____
_____
_____

Social History:

Have you ever smoked or chewed, if so what kind? _____

Quantity? _____ Year Started? _____

Ever tried to quit? _____ Date Stopped? _____

Do you drink alcohol? _____

How many drinks do you normally have? _____

How often do you normally drink? _____

If you previously drank alcohol, date stopped? _____

Have you ever used illicit drugs, if so what kind? _____

How long did you use? _____ Date Stopped? _____

Do you have a living will? ____

Family History: (circle all that apply)

							Deceased Age
Father	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Mother	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Sisters	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Brothers	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Grandparents	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Uncles	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Aunts	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____
Other:	Elevated BP	Cancer Type: _____	Diabetes	Heart Disease	Stroke	Other: _____	_____

_____ _____ _____ _____
Patient Signature Date Physician's Initials Date

Darien W. Bradford, MD

515 W. Mayfield Rd Ste 404
Arlington, TX 76014
Phone (817) 465-5311 Fax (817) 465-8569

PAST OR PRESENT CONDITIONS/SYPTOMS: PLEASE CHECK ALL THAT APPLY

CONSTITUTIONAL	Excessive Exposure to Noise	Nocturia
Change in appetite- Increase or Decrease	Olfactory Disturbance	Nocturnal Shortness of Breath
Chills/Rigor	Nose bleeding	Orthopnea
Decreased activity	Facial pain	Irregular Heartbeat/Palpitations
Fatigue	Nasal congestion	Syncope
Insomnia	Nasal Obstruction	Other:
Irritability	Runny Nose	**VASCULAR**
Lethargy	Sinusitis	Claudication
Malaise	Sneezing	Cool Extremity
Night Sweats	Change in taste	Cyanosis
Pallor	Voice Change	Erythema
Weakness	Cold sores	Pain (Vascular)
Weight Gain	Difficulty swallowing	Raynaud's
Weight Loss	Hoarseness	Thrombophlebitis
Other:	Lump in throat	Ulcer
HEENT	Mouth Sores	Varicose Veins
Headache	Painful Swallowing	Paresthesias
Burning eyes	Post Nasal Drainage	**GASTROINTESTINAL**
Double Vision	Sore Tongue	Abdominal Mass
Eye Discharge	Pharyngitis	Abdominal Pain
Dry eyes	Snoring	Bloating
Foreign Body Sensation	Tooth Pain	Blood in Stool
Itchy Eyes	Other:	Change in Bowel Habits
Nystagmus	**RESPIRATORY**	Constipation
Eye Pain	Accelerated Respirations	Diarrhea
Photophobia	Cough	Fecal Incontinence
Eye Redness	Cyanosis	Flatulence
Scotoma	Shortness of Breath	Heartburn
Floaters	Hemoptysis	Hematemesis
Tearing	Painful Respirations	Hemorrhoids
Wears Glasses	Pleuratic Pain	Jaundice
Wears Contacts	Snoring	Melena
Cataracts	Sputum	Nausea
Ear Discharge	Stridor	Rectal Bleeding
Excessive Cerumen	Wheezing	Reflux (GERD)
Ear Fullness	Frequent URI	Vomiting
Hearing Loss (Right or Left)	Known TB Exposure	Other:
Ear Infections	Other:	**GENITOURINARY**
Otalgia	**CARDIOVASCULAR**	Back Pain
Ringing in ears	Chest Pain (Cardiac Related)	Change in Urine Color
Vertigo	Edema	Cloudy Urine

Continue on back....

Darien W. Bradford, MD

515 W. Mayfield Rd Ste 404
Arlington, TX 76014
Phone (817) 465-5311 Fax (817) 465-8569

	Decreased Stream
	Decreased Urine Output
	Painful Urination
	Flank Pain
	Foul Urine Odor
	Frequent Urination
	Groin Mass
	Blood in urine
	Hesitancy
	Night Urination
	Passage Stone/Gravel
	Excessive Urine
	Suprapubic Pain
	Urgency
	Urinary Incontinence
	Other:

REPRODUCTIVE-MALE

	Circumcised
	Decreased Libido
	Erectile Pain
	Blood in Semen
	Herpes Genitalis
	Infertility
	Penile Discharge
	Scrotum/Testicular Pain
	Scrotum/Testicular Mass
	Sexual Dysfunction
	History of hydrocele
	VDRL positive
	Other:

REPRODUCTIVE-FEMALE

	Breast Lumps
	Breast Discharge
	Breast Pain
	Painful Intercourse
	Fibroids
	History of abnormal PAP Smear
	History of Infertility
	Menopausal
	Non-Oral Contraception
	Oral Contraception
	Ovarian Cysts
	Sexual Dysfunction
	Vaginal Itch
	Vaginal Discharge
	Other:

METOBOLIC/ENDOCRINE

	Abnormal Habitus
	Abnormal Hair Distribution
	Abnormal Sleep Pattern
	Change in Sleep/Awake Pattern
	Chronically Overweight
	Chronically Underweight
	Coarse Hair
	Cold Intolerence
	Excessive Diaphoresis
	Goiter
	Gynecomastia
	Hair Loss
	Heat Intolerance
	Hyperpigmentation
	Hypoglycemia
	Increase in Size
	Infertility
	Insulin Reactions
	Jaundice
	Numbness
	Excessive Thirst
	Eating too much
	Tremors
	Other:

NEUROLOGIC/PSYCH

	Aphasia
	Dizziness
	Dysarthria
	Focal Weakness
	Gair Disturbance
	Incontinence
	Incoordination
	Light-headedness
	Loss of Consciousness
	Memory Impairment
	Fainting/Near Syncope
	Paresthesias
	Seizures
	Speech Changes
	Visual Changes
	Appropriate Interaction
	Consolability
	Difficulty Contrating
	Emotional
	Depression
	Other:

DERMATOLOGIC

	Acne
	Contact Allergy
	Excessive Sweating
	Frequent Skin Infections
	Nail Changes
	Photosensitivity
	Pigment Changes
	Rash
	Change in Mole
	Other:

MUSCULOSKELETON

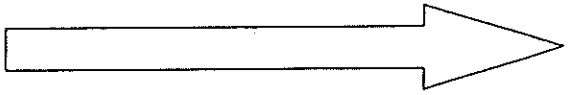
	Back Pain
	Bone/Joint Symptoms
	Muscle Pain/Weakness
	Neck Stiffness
	Other:

HEMATOLOGIC/IMMUNOLOGICAL

	Asthma
	Easy Bleeding
	Lymphadenopathy
	Easy Bruising
	Thromboembolic Events
	Other:

Patient Signature: _____ Date: _____ Physician's Initials:_____

Continue on back....



PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Darien W. Bradford, with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date #_____

_____ _____

Date *Patient/Legal Representative*

THCOBP12

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ○ OK to leave a message with detailed information
  - ○ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ○ OK to leave message with detailed information
  - ○ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

Treatment, Payment, Health Care Operations

We are permitted to use and disclose your medical information to those involved in your treatment. Privia Medical Group North Texas (Privia) (f/k/a Texas Health Care, PLLC) is a multi-specialty practice and when we provide treatment, we may request that all of your physicians share your medical information with us. For example, your care may require both primary care physicians and specialty care physicians. When we provide treatment, we may request information from all of your physicians so that we can appropriately treat you for all other medical conditions, if any.

- If your physician is a primary care physician, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

- If your physician 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.

- If your treatment has been ordered by your physician, but is being provided by an ancillary department, such as any therapies, we are permitted to use and disclose your medical information to those involved in your treatment. When we provide treatment, we may request that your physician share your medical information with us. Also, we may provide your physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service 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 ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law 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 taken in reliance 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.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also 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 that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;

- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- 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.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the 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 or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Other uses and Disclosures

We will not use or sell your protected health information for marketing or any other purposes without your expressed permission.

Your Rights Under Federal Privacy Regulations

The United States 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 a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations.

- If you have health insurance coverage and personally pay, out-of-pocket, in full for medical services provided, you may request that we not submit any information regarding these services to your insurance carrier.
- To request this restriction, notify the front desk of the physician's office. You will be provided with a separate form documenting this request. Please give or send the request to the Practice Team Liaison in this office.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative 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 record 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 requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

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

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- 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 provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- If 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. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The 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. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (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 Health-related Benefits

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

Emailing or Downloading PHI

If you email us medical or billing information from a private email address (such as a Yahoo, Gmail, etc. account), your information will not be encrypted unless you use a secure messaging portal to send it to us. If you request us to post your information in drop-boxes, on flash drives, CDs, etc., your information may not be secure. Privia is not responsible for the privacy or security of your PHI if you request that we send it to you in an unsecured manner or download or post it on a drop-box, flash drive, CD or other unsecure medium. In addition, Privia is not responsible if your PHI is redisclosed, damaged, altered or otherwise misused by an authorized recipient. In addition, if you share an email account with another person (for example, your spouse/partner/roommate) or choose to store, print, email, or post your PHI, it may not be private or secure.

Business Associates

Your PHI may be disclosed to individuals or entities who provide services to or on behalf of Privia. Pursuant to HIPAA, Privia requires these companies sign business associate or confidentiality agreements before we disclose your PHI to them. However, Privia generally does not control the business, privacy, or security operations of our business associates.

Incidental Disclosures

Despite our efforts to protect your privacy, your PHI may be overheard or seen by people not involved in your care. For example, other individuals at your provider's office could overhear a conversation about you or see you getting treatment. Such incidental disclosures are not a violation of HIPAA.

Consent to Disclose Sensitive Health and Substance Use Disorder Information

During the registration process, you consent to the release of federally assisted substance use disorder information, information regarding treatment of communicable diseases and mental health information. If you do not wish for this information to be disclosed, you must notify us in writing.

Sensitive Health Information

Federal and state laws provide special protection for certain types of health information, including psychotherapy notes, information about substance use disorders and treatment, mental health and AIDS/HIV or other communicable diseases, and may limit whether and how we may disclose information about you to others.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and

Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

Secretary of the U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877)696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

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:

Jason A. Copling, Privacy Officer
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
jcopling@priviahealth.com

This notice is effective on the following date: June 28, 2017.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority