simmons center
FOR OBSTETRICS & GYNECOLOGY

Date Completed _____

PATIENT INFORMATION:

Name _____ Goes By: _____ DOB: _____ Age: _____
Address:_____
City:_____ State: _____ Zip: _____

Driver's License #: _____ Social Security #: _____ Marital Status: S M D W

Email Address (if you would like to have access to our patient portal): _____

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

May we leave confidential messages on your voicemail? Yes / No If yes, which number: _____
Employer:
_____ Occupation: _____

*Preferred Language: English / Spanish / Chinese / Korean / Russian / French / Indian / Other _____

*Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Choose Not to Report

*Race: American Indian or Alaska Native American / Asian / Native Hawaiian or Pacific Islander /

Black or African American / White / Hispanic / Choose Not to Report / Other _____

REFERRING INFORMATION:

Physician
Referral:_____ Phone #: _____

Physician's Address: _____

_____

Patient Referral: Family Physician:

INSURANCE INFORMATION:

Name of Primary Insurance Co: _____ Copay Amt $_____ Effective Date: _____

Subscriber's Name:_____ DOB: _____ Relationship to patient: _____

ID #: _____ Group: _____ Employer: _____

Name of Secondary Insurance Co:_____

Subscriber's Name:_____ DOB: _____ Relationship to patient: _____

ID #: _____ Group: _____ Employer: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

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

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

PREFERRED PHARMACY INFORMATION:

Name: _____ Phone: _____
Address or Approximate Location:

***Information requested to meet meaningful use criteria under the Health Information Technology for Economic and Clinical Health (HITECH) Act**

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FOR OBSTETRICS & GYNECOLOGY

REVIEW OF SYSTEMS QUESTIONNAIRE

DATE COMPLETED: _____

PATIENT NAME:_____ DATE of BIRTH: _____

	Please CIRCLE below ANY that apply to you TODAY:
GENERAL:	Headaches / Appetite Good / Appetite Poor / Chills / Fever / Fatigue / Weight Gain / Weight Loss / Frequent Colds / Vision Change
HEENT / NECK:	Nose / Sinus Problems
ENDOCRINE:	Hair Loss / Excessive Sweating / Excessive Thirst / Hirsutism / Hot Flashes
RESPIRATORY:	Cough / Hemoptysis / Asthma / COPD / Shortness of Breath / Wheezing
CARDIOVASCULAR:	Chest Pain / Murmurs
GASTROINTESTINAL:	Abdominal Pain / Blood in Stool / Diarrhea / Vomiting
HEMATOLOGY:	Anemia / Blood Transfusion
GYNECOLOGY:	Vaginal Discharge / Breast Lumps / Breast Discharge / Breast Pain / Heavy Periods / Irregular Menses
GENITOURINARY:	Recurrent Urinary Tract Infections / Blood in Urine / Burning with Urination / Difficulty Urinating / Urinary Frequency / Urinary Incontinence / Urinary Urgency
MUSCULOSKELETAL:	Muscle Pain / Joint Pain
DERMATOLOGY:	Rash / Skin Cancer
NEUROLOGIC:	Loss of Consciousness /Memory Loss / Seizures
PSYCHIATRIC:	Anxiety / Depression / Eating Disorders

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Today's Date: _____ Patient Name: _____ Birth Date:_____

Reason for Today's Visit: _____

GYNECOLOGICAL HISTORY

First Day of Last Period: _____

Are your periods (please circle): Normal / Heavy in flow, Regular / Irregular in length, Non-painful / Painful

At what age did your periods begin? _____

Are you currently sexually active? YES / NO Sexual partners are: MEN / WOMEN / BOTH

Your current method of birth control (please circle): IUD / OCP / Tubal Ligation / Condom / Other _____

When was your LAST PAP SMEAR? _____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? . . . . . YES / NO
ARE YOU HPV POSITIVE? . . . . . YES / NO
Have you ever had a breast mass or lesion? . . . . . YES / NO
Have you ever had a MAMMOGRAM?. . . . . .YES / NO

MEDICAL HISTORY

HAVE YOU HAD ANY MEDICAL ILLNESSES (Please circle any that apply):

Asthma	Heart Disease	Migraines	Bleeding Disorder
High Cholesterol	Cancer	High Blood Pressure	Psychiatric Illness
Diabetes	Hypo/Hyperthyroid	Seizure Disorder	
STD (please list type): _____		Cancer (please list type):_____	

Other: _____

OBSTETRICAL HISTORY

How many times have you been pregnant? (this includes miscarriages and abortions) _____
Have you ever had a C-Section?. . . . . YES / NO
If yes, how many C-sections?_____
How many live births have you had? . . . . . ._____

MEDICATION HISTORY

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? . . . . . YES / NO
If yes, what is the drug? _____ If yes, what is the reaction? _____

Below, please list your CURRENT MEDICATIONS (both prescription and nonprescription):

DRUG NAME	DOSAGE	WHO PRESCRIBED?
1)		
2)		
3)		
4)		

SURGICAL HISTORY

HAVE YOU EVER HAD SURGERY? . . . . . YES / NO

If YES, what TYPE of surgery (please circle): Abdominal Hysterectomy, Vaginal Hysterectomy, Ovary(ies) Removed, Tonsillectomy, Gallbladder Removed (Cholecystectomy), Appendix Removed (Appendectomy), Laparoscopy, LEEP, Cryotherapy, Hysteroscopy with or w/o D&C, C-Section, Suction D&C, Tubal Ligation, Other_____

FAMILY HISTORY

MOTHER (Please circle): Living/Deceased FATHER (Please circle): Living/Deceased
Has your mother and/or sister had ovarian, breast, uterine, and/or cervical cancer? YES / NO
Please circle any below that are part of your immediate family history (mother, father, siblings):
Diabetes Cervical Cancer High Cholesterol Osteoporosis Ovarian Cancer
Heart Disease Pulmonary Embolus Uterine Cancer Hypertension Breast Cancer

SOCIAL HISTORY

Do you use any tobacco products? . . . . . YES / NO
Do you use alcohol? . . . . . YES / NO
Do you use illegal or street drugs? . . . . . YES / NO
Are you a victim of intimate partner violence? . . . . . YES / NO
Are you a victim of sexual abuse? . . . . . YES / NO
Are you around health hazards at work? . . . . . YES / NO
Do you use a seat belt? . . . . . YES / NO
Are you presently eating a healthy diet. . . . . YES / NO
Do you exercise? . . . . . YES / NO
Do you intake folic acid? . . . . . YES / NO
Do you have adequate calcium intake?. . . . . YES / NO
Do you intake caffeine?. . . . . YES / NO
Do you have an advance directive (living will)? . . . . . YES / NO
Are you an organ donor? . . . . . YES / NO

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SMOKING QUESTIONNAIRE

HAVE YOU EVER SMOKED? . . . . . YES / NO

ARE YOU A CURRENT SMOKER? . . . . . YES / NO

If YES:

- How often do you smoke cigarettes:
  - o every day
  - o some days, but not every day
- How many cigarettes a day do you smoke?
  - o 5 or less
  - o 6 -10
  - o 11-20
  - o 21-30
  - o 31 or more
- How soon after you wake up do you smoke your first cigarette?
  - o Within 5 minutes
  - o 6-30 minutes
  - o 31 – 60 minutes
  - o after 60 minutes
- Are you interested in quitting?
  - o Ready to quit
  - o Thinking about quitting
  - o Not ready to quit

ARE YOU A FORMER SMOKER? . . . . . YES / NO

If YES:

- How long has it been since you last smoked?
  - o Less than 1 month
  - o 1 – 3 months
  - o 3-6 months
  - o 6-12 months
  - o 1-5 years
  - o 5-10 years
  - o Greater than 10 years

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

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ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans to Chad Simmons, M.D., P.A. I transfer my title of reimbursement from my insurance company to Chad Simmons, M.D., P.A. I request that payment from my insurance company be made directly to Chad Simmons, M.D., P.A.

I hereby agree to pay any and all charges that exceed or are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I authorize my insurance claim form to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

PATIENT SIGNATURE (Parent or Guardian if patient a minor) **DATE**

_____

PRINTED NAME

simmons center
FOR OBSTETRICS & GYNECOLOGY

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.

EFFECTIVE SEPTEMBER 1, 2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Simmons Center for Obstetrics and Gynecology, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you

receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine/voicemail) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. We may mail appointment reminder cards to you. We may email information to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an

authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

Z. Other. May be updated to list other special circumstances relating to uses and disclosures.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your

request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a

restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Simmons Center for Obstetrics and Gynecology
Attn: HIPAA Officer
12890 Hillcrest Road, Suite 203, Dallas, Texas 75230
972-239-2777

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

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DISCLOSURE OF PATIENT INFORMATION

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____

_____

_____

_____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone #_____

Name_____ Phone #_____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information:

_____

*I am fully aware that a cell phone is not a secure and private line.

Please Print:

Patient Name_____

Patient/Guardian Signature:

_____ Date_____

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that Chad Simmons, M.D., P.A. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Chad Simmons, M.D., P.A. to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name | Patient's Date of Birth

_____ _____

Signature of Patient or Guardian | Relationship to Patient