PATIENT REGISTRATION FORM

NAME:_____ DATE:_____

DOB: _____ E-MAIL:_____

ADDRESS:_____CITY, STATE, ZIP:_____

PHONE: _____ HOME WORK CELL

PHONE: _____ HOME WORK CELL

SOCIAL SECURITY #:_____MARITAL STATUS:_____

SEX: MALE FEMALE

EMPLOYER:_____PHONE:_____

ADDRESS:_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP:_____

PHONE:_____

INSURANCE INFORMATION:

INSURANCE:_____

ADDRESS:_____

NAME OF INSURED:_____RELATIONSHIP:_____

DOB OF INSURED:_____ SEX: MALE FEMALE

GUARANTOR:_____ SAME AS PATIENT

RELATIONSHIP:_____ DOB:_____

SOCIAL SECURITY#:_____

BRIDLEWOOD FAMILY HEALTHCARE P.A.
PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

DATE:_____ LAST PHYSICAL EXAM:_____
LAST NAME:_____ FIRST NAME:_____
DOB:_____ SEX:_____ AGE:_____ MARITAL STATUS:_____
OCCUPATION:_____ ETHNICITY:_____
Due to patient confidentiality, information contained here will NOT be released to anyone without your written authorization.

MEDICAL HISTORY: (*High Blood Pressure, Diabetes, Asthma, Cancer, Heart disease, Etc.*)

_____

_____

_____

_____

_____

SURGICAL: (*Tonsillectomy, Appendectomy, Hysterectomy, Hernia, Etc.*)

_____

_____

_____

ALLERGIES NONE (If YES, please list medications and explain type of reaction i.e. hives, wheezing, upset stomach, swelling, etc.)

_____

CURRENT PRESCRIPTION MEDICATION:
Name of drug, mg dose, #tablets, # times per day

_____

_____

_____

_____

_____

Use back side (if needed)

OTC MEDICATION: (Aspirin, Tylenol, Aleve Vitamins, Herbals)

_____

_____

_____

_____

_____

Use back side (if needed)

FAMILY HISTORY

Father: Living, age:_____ Deceased, age at death:_____ (Cause) _____
Mother: Living, age:_____ Deceased, age at death:_____ (Cause) _____
Siblings: Number living:_____ Number deceased:_____ (Cause)_____

List other illnesses in your family (example: Diabetes, Heart disease, Colon Cancer, Breast Cancer, Prostate Cancer, etc.)

FAMILY MEMBER	ILLNESS
_____	_____
_____	_____

SOCIAL HISTORY

SMOKE? YES / NO If yes, how much?_____ # of packs/day _____ # of years When did you stop smoking?_____
ALCOHOL? YES / NO If yes, how much?_____

Exercise regularly? YES / NO If yes, what and how frequently? _____
Routinely wear seatbelts? YES / NO Routinely wear a helmet? YES / NO Substance Abuse? YES / NO

PATIENT/PARENT SIGNATURE:_____

Review of Symptoms

Are you currently experiencing any problems related to the following symptoms? write **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Last Eye & Dental Exam

Date - Last Eye Exam: _____

Date - Last Dental Exam: _____

Screening Exams

Cholesterol	Colonoscopy
PSA	Chest X-ray
Mammogram	Pelvic Exam
Stress Test	Blood Pressure

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Sexual History

Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N

Other (i.e. sexual trauma)

BRIDLEWOOD
FAMILY HEALTHCARE

ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Bridlewood Family Healthcare for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

I hereby authorize Bridlewood Family Healthcare to (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Bridlewood Family Healthcare on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____

Patient Name

FINANCIAL POLICY/PAYMENT PLAN POLICY

Deductibles

If you have a deductible, you will be held responsible for the amount your insurance allows for your visit. If you are unable to pay this amount in full you must pay at least $100.00 at the time of service.
We will not take payment during your annual wellness visit. Please note that if you have diagnostic services or testing done at the same time as your annual wellness visit they may be subject to your deductible.

Large Balances

If your balance exceeds $100, you must pay at least ½ of your balance within the first 30 days it becomes due. Additionally, you will need to set up a payment plan with our office regarding the remaining balance due.

Payment Plans

If you have a payment plan on file you will be responsible for contacting the office with any changes. If your credit card is declined at any time there will be an additional $25.00 fee.

Other

If your insurance does not pay for any reason, you will be responsible for the entire balance. If you do not pay a balance after 90 days you will be subject to further collection actions and possible dismissal from our practice.

_____ _____

Patient/Parent Signature Date

_____

Patient Name

Brian D. Glaser, D.O. / Bryan L. Wasson, D.O /
Michele Hampton, PA-C/ Victoria Thomas, MSN, FNP-BC, RN

IMPORTANT INFORMATION ABOUT YOU UPCOMING PHYSICAL/PREVENTIVE CARE VISIT

PREVENTIVE CARE VERSUS DIAGNOSTIC CARE – WHAT'S THE DIFFERENCE?

Preventive care includes services such as a patient history & physical exam, screening tests, and immunizations – care that you get when you're symptom-free and have no reason to believe you might be sick. Diagnostic care is what you get when you have symptoms of an illness or injury or are being followed for a chronic condition even if it's stable, and your doctor wants to diagnose or monitor the condition. This may include an office visit, tests, or treatment(s).

PREVENTIVE CARE AND DIAGNOSTIC CARE CANNOT OCCUR DURING THE SAME VISIT.

For example, you may have a physical scheduled during which your doctor needs to discusses a chronic illness you have, or you are having a problem that needs to be treated. According to Correct Coding Guidelines this cannot be considered a physical, or preventative care. According to the World Health Organization who writes the correct coding guidelines a preventative care visit is defined as an "encounter for general examination without complaint, suspected or reported diagnosis".

WHY IT MATTERS

In most cases, you don't pay anything to the doctor for preventive care. But you may have to pay some amount for diagnostic care. Both preventive and diagnostic care cannot occur at the same visit. If you are scheduled for a physical and you are ill, or you have chronic conditions that the doctor must evaluate or treat you for, your visit will be changed to a diagnostic visit and you may still have to pay some amount (co-payment, deductible, or co-insurance) for the diagnostic care. **Insurance guidelines state "Visits with presenting patient complaints, or patients that appear to be ill may not be treated as a preventive encounter".**

EXAMPLE: "I was diagnosed with high cholesterol last year and started on medication. Yesterday I went to see my doctor for my annual physical. During the visit, he also discussed my cholesterol diet and medication, reviewed possible side-effects I could have from the cholesterol medicine, and ordered lab work to monitor my condition." By insurance guidelines your visit cannot be billed as preventive and you may have to pay something (co-payment, deductible, co-insurance) for your doctor's diagnostic care for your condition even though it's not a new diagnosis.

EXAMPLE: "When I went to see my doctor for my annual physical exam, I was wheezing. The doctor completed my exam and then also treated me for the wheezing. She told me I have asthma, discussed treatment, and gave me some prescriptions." By insurance guidelines your visit cannot be billed as preventive because you were ill at the time you were seen. You may have to pay something (co-payment, deductible, or co-insurance) for the doctor's time in diagnosing and discussing your condition. of your appointment.

As a patient, it is your responsibility to know what your specific insurance plan's benefits are. We cannot bill diagnostic care as preventive care to any insurance.

IF YOU HAVE ANY QUESTIONS ABOUT YOU SPECIFIC INSURANCE PLAN'S COVERAGE, PLEASE CONTACT YOUR PLAN DIRECTLY.

Bridlewood Family Healthcare

Financial Agreement

At Bridlewood Family Healthcare, we help you to coordinate your medical expenses by filing to most major insurance plans. To assist you with understanding your financial responsibility with us, please see below:

While we are on most major networks, we cannot guarantee that we are in network with any specific insurance.

It is your responsibility to confirm with your insurance carrier that we are in network with your particular plan. Failure to do so may result in you paying for the services completely if your insurance denies them as out of network.

We are unable to quote specific coverage. All coverage is specific to the plan you selected through your employer or broker.

To fully understand your individual insurance policy, **it is your responsibility to contact your insurance to discuss your benefits**.

You are required to provide a copy of all insurance plans that you currently have and a photo ID.

If your insurance should change, it is your responsibility to provide updated information for your Account within 15 days of the date services are rendered. Failure to do so will result in you being billed for all services.

If a copay, co-insurance, or deductible is required for your policy, it is due at the time services are rendered unless an agreement has been pre-approved.

Services and procedures are coded and billed based on what the provider has determined medically necessary. Your individual insurance plan will process your claims based on the benefits that you have selected.

We will not bill sick/problem/prescription refill visits as preventative care. To do so would be fraudulent according to correct coding guidelines.

We utilize LabCorp for our lab services. According to your insurance plan, you may receive a bill from the lab based on the benefits that you selected. **You must contact your insurance company/lab company to discuss your bill**. If your insurance requires you to have lab services at another lab, you must notify us each time labs are ordered for you. You will be required to go to your insurance's preferred lab's draw station. We can only draw labs for Labcorp.

We may order diagnostic services such as x-rays, scans, and MRI's to assist with your medical care. We do not know which facilities are in network with your particular plan. It is your responsibility to know your policy coverage for those services. Please call your insurance or the testing facility prior to having the service to make sure they are in network.

Policy/Claim Information:

1. Your insurance is a contract between you and your employer/insurance company.
2. Your insurance sets the prices for each service and we adjust our pricing down based on your insurance's instructions. We do not have any control over how much or how little your insurance allows for each service. If you do not agree with their pricing, please contact your insurance carriers. It is against our contract with them to make further adjustments.
3. It is possible that your insurance may not cover all the services that are rendered. Many insurances have strict limits on what they consider preventative care and may deny some services even if they are rendered at the time of a preventative care visit. It is your responsibility to know your policy limitations.
4. All coding will be done based on the services rendered and by the national coding guidelines. Codes will not be modified to fit a certain category of benefits.
5. In the event that you have a balance after your insurance has paid, it is your responsibility to pay the balance due within 30 days. If you cannot pay the entire amount, please see our practice manager to make payment arrangements. We reserve the right to deny you credit based on your payment history. We do follow general collections guidelines.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read understand and agree to follow this agreement.

Print Patient Name: _____

Date of Birth: _____

Signature of Patient (or guardian): _____

Signer's Name if not Patient: _____

Date: _____

Patient Consent of Disclosure of Information

I authorize the release of my protected health information to the following person(s):

Name: _____

Address: _____

Phone: _____

Relationship to Patient: _____

OR

{ } I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE

Limitations on the information you may release subject to this release form are as follows: _____

_____

_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Initials: _____ Date: _____

_____

Patient Signature (or Parent, Guardian, or Legal Representative) Date

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protective health information, to the person(s) listed above.

Medical Records Release Form

Medical Records Release Requested From:

Doctor's Office: _____

Address: _____

Phone Number: _____

Fax Number: _____

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

Bridlewood Family Healthcare
3400 Long Prairie Road, Suite 200
Flower Mound, TX 75022
P) 972-899-6300
F) 972-899-6020

Limitations on the information you may release subject to this release form are as follows:_____

_____

The reason or purpose for this release of information are as follows:_____

_____

Patient Name: _____ DOB: _____

_____

Signature of Patient (Parent, Guardian, or Legal Representative) Date

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing the information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

{ } I DO NOT WISH TO HAVE MY RECORDS RELEASE

Bridlewood Family Healthcare

Controlled Medications
Management Agreement

The purpose of this Agreement is to prevent any misunderstandings about any controlled medications that may be prescribed by your provider. This Agreement will help you and your doctor to comply with the law regarding controlled medications.

Each line must be INITIALED to show acceptance of this agreement.

___ I understand this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

___ I understand that if I break this Agreement, my provider will stop prescribing these controlled medicines.

___ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

___ I will not use any illegal controlled substances, including marijuana, cocaine, etc.

___ I will not share, sell, or trade my medication with anyone.

___ I will not attempt to obtain any controlled medicines, including opiod pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider.

___ I will safeguard my controlled medicine from loss or theft. Lost or stolen medicines will not be replaced.

___ I agree that refills of my prescriptions for controlled medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on weekends.**

___ I agree to use _____ Pharmacy, located at

_____.

Telephone number _____, for filling prescriptions for my pain or controlled medications.

___ I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

___ I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of controlled medicine.

___ I will schedule an appointment with my provider every month to 3 months and this will be up to the discretion of the provider due to my treatment plan.

___ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at greater rate will result in my being without medication for a period of time.

___ If requested, I will bring all unused pain medicine to my office visit.

___ I understand that if I break this Agreement, my provider will stop prescribing this controlled medicine.

___ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. If I requested, a copy of this document has been given to me.

This agreement is entered into effect on the _____ day of _____, _____.
(Day) (Month) (Year)

Print Name: _____ **Date of Birth:** _____

Patient signature: _____

Bridlewood Family Healthcare, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

Our Practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' 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 your Notice of Privacy Practices.

_____

Print Patient Name Signature of Patient

_____

Signature of Patient/Guardian if Minor Relationship of Patient

****

Notice of Financial Interest

I have been informed that my physician ***Dr. Brian D. Glaser*** has a financial interest in the following healthcare facilities:

Texas Health Presbyterian Hospital Flower Mound
Flower Mound, TX 75028
(469) 322-7000

I understand that my Physician may refer me to the facility listed above or any other healthcare facility of my choice.

I acknowledge that I have read this Notice of Financial Interest and have been able to ask questions and receive answers regarding it.

_____

Patient (Guardian) Signature

Bridlewood Family Healthcare, P.A.
Brian D. Glaser, DO

_____

Date

BRIDLEWOOD
FAMILY HEALTHCARE

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your healthcare provider. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Healthcare Provider for Routine Physical Exams and Other Recommended Health Screenings

I understand that my healthcare provider will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, colonoscopies, pap smears, etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my healthcare provider only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my healthcare provider to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my healthcare provider will want to know how my condition progresses after I leave the office. Returning to my healthcare provider on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my healthcare provider might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my healthcare provider will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my healthcare provider's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my healthcare provider's office within the time specified, I will call the office for my test results.

Follow the Office Policy for Medication Refills

I understand that a critical part of my treatment involves taking my medication as prescribed by my healthcare provider. I understand that I need to have regular follow ups to monitor how I am doing on my medication. I understand that I must make an appointment for a visit to refill controlled medications, these medications cannot be refilled between appointments. I understand that I need to ask my pharmacy to contact my healthcare provider before I run out of any medication. There is a 24-48 hour turnaround for all medication refills.

Inform My Healthcare Provider if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my healthcare provider may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my healthcare provider know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____

Patient Signature Date

3400 Long Prairie Road Suite 200 Flower Mound Tx 75022
(972) 899-6300

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 READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY

Effective January 1, 2012

The following is the privacy policy ("Privacy Policy") of Bridlewood Family Healthcare ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information

that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

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. We may contact you to raise funds for Covered Entity.

If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable

cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Bridlewood Family Healthcare 3400 Long Prairie Road Suite 200 Flower Mound TX 75022.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Bridlewood Family Healthcare 3400 Long Prairie Road Suite 200 Flower Mound TX 75022.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Darla Long at Bridlewood Family Healthcare 3400 Long Prairie Rd Suite 200 Flower Mound Tx 75022 (972) 899-6300 darla@bridlewoodfamilyhealthcare.com. A complaint must name the entity that is the subject of the complaint and

describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Bridlewood Family Healthcare 3400 Long Prairie Rd Suite 200 Flower Mound Tx 75022 or at the following website address. Bridlewoodfamilyhealthcare.com. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Darla Long at the address, telephone number, or e-mail address listed above.

BRIDLEWOOD
FAMILY HEALTHCARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Practice reserves the right to modify the privacy practices outlined in the notice.

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 your Notice of Privacy Practices.

_____ _____

Print Patient Name Patient Signature

_____ _____

Parent/Guardian Signature (if Minor) Date

NOTICE OF FINANCIAL INTEREST

I have been informed that my physician Dr. Brian D. Glaser has a financial interest in the following healthcare facilities:

Texas Health Presbyterian Hospital Flower Mound
Flower Mound, TX
(469) 322-7000

I understand that my Physician may refer me to the facility listed above or any other healthcare facility of my choice.

I acknowledge that I have read this Notice of Financial Interest and have been able to ask questions and receive answers regarding it.

_____ _____

Patient (Guardian) Signature Date