Authorization to Release Protected Health Information to Delegate

Patient Name: _____ DOB: _____

By signing this form, I authorize B-C OB-GYN LLC to disclose protected health information such as office visit consultations, lab tests, x-rays or other test results to the person(s) listed below. I understand that it is my responsibility to update this release if necessary and/ or remove delegates.

B-C OB-GYN LLC may release my protected health information to the following delegate(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

B-C OB-GYN LLC as a courtesy will contact patients regarding upcoming appointments, lab or tests results. This may include pre-recorded appointment reminders to the numbers provided to our office. Please indicate the manner in which these messages may be left.

_____ Primary contact number (home/work/cell)
Initial

_____ Secondary contact number (home/work/cell)
Initial

_____ Only in person or via direct phone discussion (no messages)
Initial

_____ _____
Patient/Delegate Signature Date

_____ _____
Witness Date

Acknowledgement of Conditions of Services

PATIENT: _____DOB_____

_____ **Assignment of Benefits and Release of Patient Healthcare Information**
I hereby authorize **B-C OBGYN LLC** to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payer, including but not limited to my insurance carrier, Medicare, Medicaid, and any other payer or agency.

_____ I also hereby authorize payment of insurance benefits under the terms of my policy directly to **B-C OBGYN LLC** for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

_____ **Financial Agreement and Statement of Responsibility**
For and in consideration of services rendered or to be rendered by **B-C OB-GYN LLC** I agree to pay said office for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

_____ **Consent to Medical Treatment by Physician**
I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at **B-C OB-GYN LLC.**

_____**Acknowledgement of Receipt of Office Policies**
I, or authorized representative/legal guardian acting on behalf of the patient have received a copy of office policies which explains the financial policy and general operations of **B-C OB-GYN LLC**.

_____**Acknowledgement of Receipt of B-C OB-GYN LLC Privacy Practices**
I, or authorized representative/legal guardian acting on behalf of the patient have reviewed how the **B-C OB-GYN LLC** Privacy Practice which explains how my protected health information will be used and disclosed.

_____ _____
Patient/Guarantor Signature **Date**

B-C OBGYN, LLC

PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Our treatment relationship is a partnership and we look forward to helping you achieve the best health outcomes possible.

First Time Visit: Please arrive at least 30 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications or a list of your medications. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. Payment is due at the time of service.

Follow-Up Visits: Please arrive 15 minutes before your schedule appointment time. It is our goal for you to be ready to see your physician on time. Notify us if you have any changes in your insurance or contact information. Please make us aware of any significant updates in your medical history, such as hospital or urgent care visits, and any changes in your medications by another healthcare provider. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. Payment is due at the time of service.

Follow-up Care: Your treatment plan may involve follow-up care. As such, we may schedule you for diagnostic tests, follow-up appointments with us or other providers. If you do not keep the appointment, it is important that you contact us to discuss alternatives. Likewise, if you decide to seek care from another provider, please let us know. It is our policy to inform you of test results, however, if you have not received your test results within the expected time, please contact our office. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. Payment is due at the time of service.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss you appointment without following the cancellation protocol then you will be charged $25.00. If you miss 3 or more appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written notification if this is the case.

We respectfully request that you turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Name Date

B-C OBGYN, LLC

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.

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new or revised Notice in our office or on our website: b-cobgyn.com
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. **We** may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following: Billing companies, Insurance companies, Health plans, Government agencies in order to assist with qualification of benefits and/or Collection agencies.

Example: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use of disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations

Examples: Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.

Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.We may also use your information to assist in resolving problems or complaints within the practice.

We may use of disclose your PID in other situations without your permission:

If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.

Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

Correctional Institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able *to* agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use of disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health informationn to an authorized public or private entity *to* assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. A records release form is available in our office or on our website (b-cobgyn.com) for you to complete, date and sign, in order to get a copy of your records.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health

information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based free for a copy of the records.

You have the right to request a restriction ofyour protected health information.

You may request for this practice not to use of disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restricted request we will honor the restriction request unless the information is needed *to* provide emergency treatment.

There is one exception: We must accept a restriction request *to* restrict disclosure of information to a health plan if
you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.

You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

The U.S Department of Health and Human & Services Office of Civil Rights
200 Independence Ave SW
Washington D.C 2001
(202) 619-0257

This notice was published and becomes effective on March 28, 2022.