Methodist
McKINNEY HOSPITAL

Patient Information:

Name:_____**DOB:**_____/_____/_____

SS#:_____-_____-_____**Sex:** F M

Marital Status: Married Single Widowed Separated

Address:_____

City:_____**State:**_____**Zip Code**: _____

Phone Number: (_____**)**_____-_____
Date of Injury:_____/_____/_____

Employer Name: _____
Email Address: _____

Ethnicity: □ **Hispanic** □ **Non-Hispanic** □ **Undisclosed/Decline to specify**

Race: □ **African American/Black** □ **American Indian/Alaskan Native** □ **Asian**
□ **Caucasian/White** □ **Hispanic/Latino** □ **Native Hawaiian/Other Pacific Islander**
□ **Other** □ **Decline to specify**

Guarantor Information:

Name:_____**DOB:**_____/_____/_

_____**SS#:**___-_____-_____**Sex:** F M

Phone Number: (____**)**_____-_____

Address:_____

City:_____**State:**_____**Zip Code:** _____

Relationship to Patient: _____

Employer Name: _____

Emergency Contact:

Name:_____**Phone Number: (**_____**)**_____-_____
Relationship to Patient: _____

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Primary Insurance:

Policy Holder Name :_____

SS#_____ DOB:_____/_____/_____

Gender: Female Male Relationship to Patient: _____

Address:_____

City:_____State:_____Zip Code: _____

Employer Name: _____

Secondary Insurance:

Policy Holder Name:_____

SS#_____ DOB:_____/_____/_____

Gender: Female Male Relationship to Patient: _____

Address:_____

City:_____State:_____Zip Code: _____

Employer Name: _____

How Did You Hear About Us?

☐ Referred by Doctor - Physician Name:_____ Phone:(_____) _____-_____

☐ Health/Wellness Facility (name:_____)

☐ Insurance Listing/Search Results

☐ Internet Search Engine (please circle the best option): Bing Google Yahoo Yelp Facebook

☐ Attorney/Law Firm (name:_____)

☐ Preferred Employer/HR Department (company name:_____)

☐ Family Member/Friend Recommendation (name:_____)

☐ Other:_____

_____ _____

Patient or Guardian Signature: **Date**

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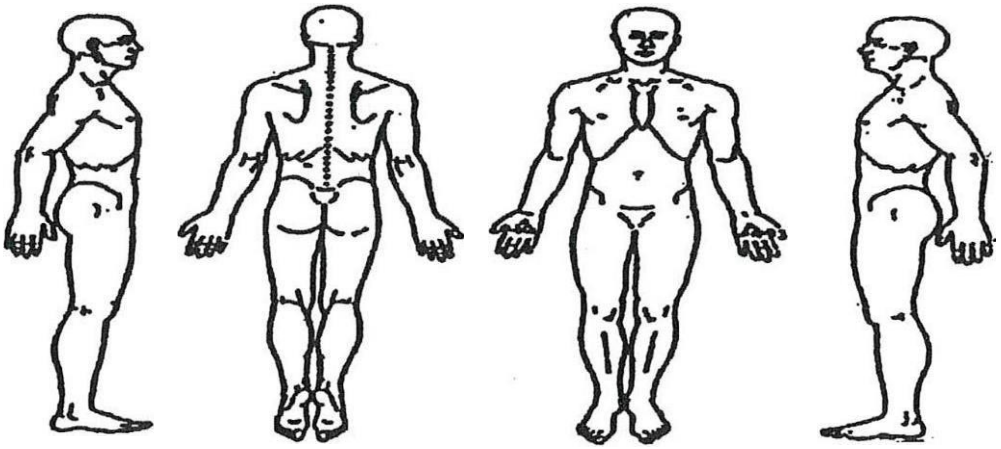
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. **Today's problem will be filed as:** □ Insurance/ Self Pay □ Auto Accident □ Workman's Compensation

2. **What is your chief complaint?** _____

3. **Indicate on the drawings below where you have pain/symptoms:**



4. **How would you describe the type of pain?**

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric-like with motion
□ Stiff	□ Other: _____

5. **How long have you had this problem?** _____

Date of Injury? _____

6. **How do you think your problem began?** _____

7. **How often do you experience your symptoms?**

□ Constantly (76-100% of the Time)	□ Occasionally (26-50% of the Time)
□ Frequently (51-75% of the Time)	□ Intermittently (1-25% of the Time)

8. **On a scale from 0-10 (10 being the worst), how would you rate your pain?**
0 1 2 3 4 5 6 7 8 9 10 *{Please circle)*

9. **Do you consider this to be a severe problem?**
□ Yes □ Yes, at times □ No

10. **What aggravates your problem?** _____

11. **What alleviates your problem?** _____

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12. How are your symptoms changing with time?

☐ Getting worse ☐ Staying the same ☐ Getting better

13. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Other _____
☐ Massage Therapist ☐ Physical Therapist ☐ No previous treatment

14. What is your: Height_____ Weight_____ Date of Birth _____

Occupation _____

15. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

16. Rate your level of exercise activity:

☐ Strenuous ☐ Moderate ☐ Light ☐ None

17. Indicate if you suffer from or have immediate family members with any of the following:

Rheumatoid Arthritis ☐ Self ☐ Parent ☐ Sibling ☐ Grandparent ☐ Unsure
Lupus ☐ Self ☐ Parent ☐ Sibling ☐ Grandparent ☐ Unsure
Heart Problems ☐ Self ☐ Parent ☐ Sibling ☐ Grandparent ☐ Unsure
Diabetes ☐ Self ☐ Parent ☐ Sibling ☐ Grandparent ☐ Unsure ☐ **Type I** ☐ **Type II**
ALS ☐ Self ☐ Parent ☐ Sibling ☐ Grandparent ☐ Unsure
Cancer ☐ Self ☐ Parent ☐ Sibling ☐ Grandparent ☐ Unsure

For the conditions listed below, please check the "past" column if you have had the condition in the past; if you presently have a condition listed below, please check the "present" column.

Past	Present		Past	Present		Past	Present
☐	☐ Headaches		☐	☐ High Blood Pressure		☐	☐ Diabetes
☐	☐ Neck Pain		☐	☐ Heart Attack		☐	☐ Excessive Thirst
☐	☐ Upper Back Pain		☐	☐ Chest Pains		☐	☐ Frequent Urination
☐	☐ Mid Back Pain		☐	☐ Stroke		☐	☐ Tobacco Use
☐	☐ Low Back Pain		☐	☐ Angina		☐	☐ Dependence ☐ Drug ☐ Alcohol
☐	☐ Shoulder Pain		☐	☐ Kidney Stones		☐	☐ Allergies
☐	☐ Elbow Pain		☐	☐ Kidney Disorders		☐	☐ Depression
☐	☐ Wrist Pain		☐	☐ Bladder Infection		☐	☐ Systemic Lupus
☐	☐ Hand Pain		☐	☐ Painful Urination		☐	☐ Epilepsy
☐	☐ Hip Pain		☐	☐ Loss of Bladder Control		☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain		☐	☐ Prostate Problems		☐	☐ HIV/AIDS
☐	☐ Lower Leg Pain		☐	☐ Abnormal Weight ☐ Gain ☐ Loss			☐ COPD
☐	☐ Knee Pain		☐	☐ Loss of Appetite		☐	☐ Anxiety
☐	☐ Foot Pain		☐	☐ Abdominal Pain		☐	☐ Liver Disorder
☐	☐ Jaw Pain		☐	☐ Ulcer		☐	☐ Rheumatoid Arthritis
☐	☐ Ankle Pain		☐	☐ Hepatitis ☐ A ☐ B			
☐	☐ Joint Pain/Stiffness		☐	☐ Gall Bladder Disorder			**Females Only**
☐	☐ Arthritis		☐	☐ General Fatigue		☐	☐ Hormonal Replacement Therapy
☐	☐ Cancer		☐	☐ Muscular Incoordination		☐	☐ Pregnancy
☐	☐ Tumor		☐	☐ Visual Disturbances		☐	☐ Birth Control
☐	☐ Asthma		☐	☐ Dizziness			
☐	☐ Chronic Sinusitis		☐	☐ Acid Reflux			

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18. List all prescription and over-the-counter medications you are currently taking:

_____

19. List all nutritional supplements you are currently taking:

_____

_____

20. List all surgical procedures you have undergone:

_____

_____

21. What activities do you do at work?

Sit	1	2	3	4	6	7	8+ hours daily
Stand	1	2	3	4	6	7	8+ hours daily
Computer Work	1	2	3	4	6	7	8+ hours daily
On the Phone	1	2	3	4	6	7	8+ hours daily
Drive	1	2	3	4	6	7	8+ hours daily
Other Activities	1	2	3	4	6	7	8+ hours daily
Manual labor	1	2	3	4	6	7	8+ hours daily
Reading	1	2	3	4	6	7	8+ hours daily
Travel frequently	1	2	3	4	6	7	8+ hours daily

22. What activities do you enjoy outside of work?

_____

23. Have you ever been hospitalized? □ Yes □ **No**

If yes, why?.....

24. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? □ Yes □ **No**

If yes, what, and when? _____

25. Is there anything else you wish to let the doctor know about your visit today? □ Yes □ **No**

If yes, what? _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature: _____ **Date:** _____

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PERMISSION TO RELEASE MEDICAL OR FINANCIAL INFORMATION

Patient Name:_____DOB: _____

Preferred Contact Information

Primary Telephone: _____ Cell____ Home_____Work_____

Secondary Telephone: _____ Cell_____Home_____Work_____

_____OK to leave message with detailed information
_____Leave message with call back number only

We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general Medical condition, diagnosis, and scheduling of appointments. Please update this information promptly if your preferences change.

I authorize the release of information to:

Name:_____DOB:_____Relationship:_____

Name:_____DOB:_____Relationship:_____

Name:_____DOB:_____Relationship: _____

I understand that I have the right to change this authorization at any time.

_____ _____

Patient or Guardian Signature Date

Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon. A separate consent for specific treatment or services may need to be signed in addition to this form as required by hospital policy.

Legal Relationship Between Hospital and Physician: All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

Release of Information: I agree that the Hospital may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records to any third-party payers, including but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the hospital for treatment and care, the hospital has permission to disclose pertinent information to family members, friends or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclose it. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

Advanced Directives: I understand that advance directives may include living wills or other probate arrangements, durable powers of attorney or appointment of a "healthcare surrogate".

Please read and initial all applicable statements and Circle the words {DO or DO NOT}

1. I DO have an executed Advanced Directive and have been requested to supply a copy to the hospital. INITIAL_____
2. I DO NOT have an executed Advance Directive. The hospital has offered me information on Advanced Directives which I {**DO** or **DO NOT**} wish to receive. INITIAL_____
3. I DO have an executed Durable Power of Attorney for Healthcare Decisions. INITIAL_____
4. I DO NOT have an executed Durable Power of Attorney for Healthcare Decisions. The hospital has offered me information on Durable Power of Healthcare which I {**DO** or **DO NOT**} wish to receive. INITIAL_____

Patient Visitation Rights: *Methodist McKinney Hospital encourages and facilitates visitation in a manner that promotes healing, balances the needs of all patients and visitors, and creates a safe and secure environment.*

- Methodist McKinney Hospital (MMH) implements practices to assure the patients' full and equal right to choose whom they want to visit them and provide support while they are in the hospital. Visitors of choice may include spouses, family members, domestic partners, friends, or other individuals regardless of category of acquaintance.
- To protect the privacy of all patients and provide an environment where care can be effectively provided to the patient, visiting hours may be designated and the number and age of visitors may be limited. There are also times when it may be necessary to reasonably restrict visitation to provide necessary care for the patient. Reasons for any limitations or restrictions will be explained to the patient and their support person by the healthcare provider. INITIAL_____

Personal Valuables: The hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats, and fur garments or other articles of unusual value and small size. The hospital shall not be liable for loss or damage to any other personal property. The patient agrees to send valuables home with family members or in a rare situation or emergency the patient will notify their nurse that they need their valuables deposited with the hospital for safekeeping at which time valuables will be itemized, patient will sign valuable receipt along with two hospital employees.

Financial Agreement and Itemized Statements: In consideration of the Methodist McKinney Hospital furnishing services and supplies to the above-named patient, I agree to pay Methodist McKinney Hospital, its agents, and assigns, all sums of money which shall become due on the account of the above-named patient with Methodist McKinney Hospital in accordance with its regular rates and terms. I understand that although the patient and other may also be responsible for paying this account by virtue of an express

or implied agreement, or otherwise, I shall be responsible to pay for the entire account, and I further understand this agreement in no way relieves any other such party of any obligation to pay this account. I understand that insurance will not pay for the total cost of a suite, and I agree to pay any charge toward the cost of a suite that insurance does not pay. I further understand that should this account become delinquent, this account may be referred to or sold for collections. All accounts are due and payable in Collin County, Texas.

I understand that I have the right by Texas Law to receive an itemized statement of billed services within 30 days of my discharge and before receiving collection activity from the hospital. Methodist McKinney Hospital maintains certain policies related to billing and collection on our website at methodistmckinneyhospital.com under the section Patients and Visitors, then select Financial Assistance. For questions related to billing or payment after discharge, please contact our customer service department at 972-569-2700.

_____By opting in, I agree to receive itemized statements electronically through my health care portal, My Chart and all future itemized statements will be provided electronically. I understand that itemized statements are available in My Chart no later than 4 days from the date of discharge.

_____By opting out, I do not agree to receive itemized statements electronically through my health care portal, My Chart. Itemized statements will be mailed to the address on file not later than 14 days from the date of discharge.

Consent for Wireless Calls, and Email: I acknowledge and agree that Methodist McKinney Hospital and any affiliates or vendor thereof, including collection or billing companies, may contact me by email, telephone, or text message to any telephonic number or email address I have provided to you, any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as autodialed calls and prerecorded messages at that telephone number from the hospital, agents, and independent contractors, including servicers and collection agencies regarding the hospitalization, the services rendered, or my related financial obligations.

Disclosure of Ownership: The physician who refers you to our Hospital may have an ownership interest in this hospital. You are free to choose another hospital in which to receive services.

Medicare Certification, Authorization to Release Information, and Payment Request: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

HIPAA Privacy Notice: I acknowledge that I have received the Hospital HIPAA Privacy Notice and have had the opportunity to review its content._____(Please initial)

Patient Bill of Rights: I acknowledge that I have received the Patient Bill of Rights._____(Please initial)

I certify that I have read this document and I am the patient, or I am duly authorized to execute it and accept its terms.

Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. It is agreed that payment to the hospital, pursuant to this authorization by an insurance company shall discharge said insurance company of all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment. I authorize Methodist McKinney Hospital to submit an Appeal on my behalf, to my insurance company, to get the claim(s) paid that were billed from the services performed at Methodist McKinney Hospital.

_____ (Please initial) **Photography and Filing for purposes of Diagnosis, identification, and Treatment**: I consent to the taking of pictures for purposes of identification and treatment of my condition or disease, and the inclusion of such pictures in the medical record. In addition, I consent to the use of such pictures for medical, scientific, or educational purposes, providing my identity is not revealed by the pictures or descriptive texts accompanying the pictures.

Healthcare Service Plan Obligation: This hospital maintains a list of healthcare service plans with which it contracts. A list of such plans is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the hospital if he/she belongs to a plan which does not appear on the above-mentioned list.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

rate. I agree to pay the hospital in accordance with its regular rates and terms. TERMS: Net 30 days from date of invoice unless otherwise indicated on a promissory note. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees.

Date:_____ Time:_____ AM/PM

Signature:_____

(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship:_____

Witness:_____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative:

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, Healthcare Service Plan Obligation provisions above.

Date:_____ Time:_____ AM/PM

Signature:_____

(Financially responsible party)

Witness:_____

Methodist McKinney Hospital and the medical staff have adopted the following statement of Patient Rights and Patient Responsibilities. This list includes, but is not be limited to the following and is delivered upon each patient encounter to the patient. In the event of an incapacitated patient the information is delivered to the designated patient representative.

PATIENT'S RIGHTS:

1. You have the right to the Hospital's reasonable response to your requests and needs for treatment or service, within the Hospital's capacity, its stated mission, and applicable law and regulation.
2. You have the right to considerate and respectful care. This right includes the consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness. The comfort and dignity of all patients is optimized to the best of ability while delivering care. For care of the AND (Allow Nature Death) patient, this care includes treating primary and secondary symptoms that respond to treatment as desired by the patient or surrogate decision maker, effectively managing pain, and acknowledging the psychosocial and spiritual concerns of the patient and the family regarding dying and the expression of grief by the patient, significant other, and family.
3. Become informed of his or her rights as a patient and participate in care and in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
4. Exercise these rights and have reasonable access to care without regard to sex, sexual orientation, cultural, economic, educational, or religious background or the source of payment for care.
5. Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment, and/or exploitation.
6. Access protective and advocacy services or have these services accessed on the patient's behalf.
7. Appropriate assessment and management of pain.
8. Remain free from seclusion or restraints of any form that are not medically/behaviorally necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
9. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
10. Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
11. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
12. Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
13. Formulate advance directives regarding his or her healthcare, and to have Hospital staff and practitioners who provide care in the Hospital comply with these directives (to the extent provided by state laws and regulations).
14. Have a family member, significant other, or representative of his or her choice notified promptly of his or her admission to the Hospital and designate visitors, non visitors at their choosing to include same sex partners, family, or designee support person(s).
15. Have his or her personal physician notified promptly of his or her admission to the Hospital.
16. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
17. Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the Hospital. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
18. Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.

19. Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).
20. Reasonable responses to any reasonable request he/she may make for service.
21. Leave the Hospital even against the advice of his/her physician.
22. Reasonable continuity of care.
23. Be advised of the Hospital grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the Hospital contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance, and the grievance completion date.
24. Be advised if Hospital/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment, or services.
25. Full support and respect of all patient rights should the patient choose to participate in research, investigation, and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation, and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
26. Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the Hospital.
27. Examine and receive an explanation of his/her bill regardless of source of payment.
28. Know which Hospital rules and policies apply to his/her conduct while a patient.
29. Designate a representative to make decisions to exercise the patient's right to participate in the development of care and to make decisions regarding medical care on behalf of the patient.
30. Pastoral and other spiritual services.

All Hospital personnel, medical staff members, and contracted agency personnel performing patient care activities shall observe these patients' rights.

PATIENT RESPONSIBILITIES ARE AS FOLLOW:
The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
2. The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
3. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
4. The patient is responsible for following the plan of care established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
5. Accepting the consequences of failing to follow the recommended course of treatment or using other treatments.
6. The patient is responsible for keeping appointments and for notifying the Hospital or physician when he/she is unable to do so.
7. The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
8. Respecting the hospital property and that of other persons.
9. The patient is responsible for following Hospital rules and regulations concerning patient care and conduct.

TO REPORT CONCERNS ABOUT PATIENT SAFETY AND QUALITY OF CARE:

1. Hospital Risk Coordinator (972) 569-2742
2. The Joint Commission (630)792-5800 or By Mail: Office of Quality & Patient Safety, The Joint Commission One Renaissance Boulevard Oakbrook Terrace, Illinois 60181

YOUR HEALTH INFORMATION RIGHTS:

Right to Access. You have the right to access, or to inspect and obtain a copy of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form so we have the information we need to process your request. You may request that your records be provided in an electronic format and we can work together to agree on an appropriate electronic format. Or you can receive your records in a paper copy. You may also direct that your protected health information be sent in electronic format to another individual. You may be charged a reasonable fee for access. We can refuse access under certain circumstances. If we refuse access, we will tell you in writing and in some circumstances you may ask that a neutral person review the refusal.

Right to Amend Your Records. If you feel that your protected health information is incorrect or incomplete, you may ask that we amend your health records. To exercise this right, you must contact the Privacy Officer to complete a specific form stating your reason for the request and other information that we need to process your request. We can refuse your request if we did not create the information, if the information is not part of the information we maintain, if the information is part of information that you were denied access to, or if the information is accurate and complete as written. You will be notified in writing if your request is refused and you will be provided an opportunity to have your request included in your protected health information.

Right to an Accounting. You have a right to an accounting of disclosures of your protected health information that is maintained in a designated record set. This is a list of persons, government agencies, or businesses who have obtained your health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. There are specific time limits on such requests. You have the right to one accounting per year at no cost.

Right to a Restriction. You have the right to ask us to restrict disclosures of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. If you self-pay for a service and do not want your health information to go to a third party payor, we will not send the information, unless it has already been sent, you do not complete payment, or there is another specific reason we cannot accept your request. For example, if your treatment is a bundled service and cannot be unbundled and you do not wish to pay for the entire bundle, or the law requires us to bill the third party payor (e.g., a governmental payor), we cannot accept your request. We do not have to agree to any other restriction. If we have previously agreed to another type of restriction, we may end that restriction. If we end a restriction, we will inform you in writing.

PRIVACY NOTICE For your records only

Right to Communication Accommodation. You have the right to request that we communicate with you in a certain way or at a specific location. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us the information that we need to process your request.

Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

Right to Obtain the Notice of Privacy Practices. You have the right to have a personal copy of this Notice. This form serves as that Notice and will be provided to you when you first register for care and treatment. You may request additional copies from the hospital registration staff or you may also go to our website at: http://www.methodistmckinneyhospital.com

Right to File a Complaint. If you believe your privacy rights as described in this Notice have been violated, you may file a written complaint with our Privacy Officer. The name and address information are listed below. Or, you may file a written complaint with the U.S. Department of Health and Human Services – Office for Civil Rights, Regional Office at: 1301 Young Street, Suite 1169 Dallas, TX 75202 (800) 368-1019 or through www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for protected health information that we currently maintain in our possession, as well as for any protected health information we receive, use, or disclose in the future. A current copy of the Notice will be posted in our Hospital.

TO CONTACT OUR PRIVACY OFFICER OR ASK QUESTIONS ABOUT YOUR PROTECTED HEALTH INFORMATION, HIPAA PRIVACY OR THIS NOTICE, PLEASE CONTACT:

Privacy Officer
8000 W. Eldorado Parkway
McKinney, TX 75070
972-569-2710
privacyofficer@txmmh.com

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT

Methodist McKINNEY HOSPITAL

8000 W Eldorado Parkway, McKinney, TX 75070
(972) 569-2700 - Fax (972) 569-2799

PRIVACY NOTICE

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

WHY WE ARE PROVIDING THIS NOTICE:

Methodist McKinney Hospital compiles information relating to you and the treatment and services you receive. This information is called protected health information (PHI) and is maintained in a specific set of records for you and your care/treatment. We may use and disclose this information in various ways. Sometimes your agreement or authorization is necessary for us to use or disclose your information, and sometimes it is not. This Notice describes how we use and disclose your protected health information and your rights. We are required by law to give you this Notice, and we are required to follow it. We may change this Notice at any time if the law changes or when our policies change. If we change the Notice you will be given a revised Notice. You may also access this notice at: http://www.methodistmckinneyhospital.com

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION THAT MAY BE MADE *WITHOUT YOUR AUTHORIZATION*:

For your treatment. We may share your protected health information with other treatment providers. For example, if you have a heart condition we may use your information to contact a specialist and may send your information to that specialist. We may send your information to other treatment providers, as necessary.

For payment. We may share your protected health information with anyone who may pay for your treatment. For example, we may need to obtain a pre-authorization for treatment or send your health information to an insurance company so it may pay for treatment. However, if you pay out of pocket for your treatment and make a specific request that we not send information to your insurance company for that treatment, we will not send that information to your insurer except under certain circumstances. We may also contact you regarding payment of your bill.

For our healthcare operations. We may use and disclose your protected health information when it is necessary for us to function as a business or provide services. When we contract with other businesses to do specific tasks or services for us, we may share your protected health information related to those tasks or services, (for example, assisting with billing or insurance claims). When we do this, the business agrees in the contract to protect your health information and use and disclose such health information only to the extent necessary to complete the assigned tasks or as we would use it in the Hospital. These businesses are called 'Business Associates" and our contract for their services is called a "Business Associate Agreement." Another example is our internal review of your protected health information as part of our quality process, patient safety review and staff performance.

Methodist McKINNEY HOSPITAL

8000 W Eldorado Parkway, McKinney, TX 75070
(972) 569-2700 Fax (972) 569-2799

For Surveys. We may use and disclose your protected health information to contact you to assess your satisfaction with our services.

For providing your information on treatment alternatives or other services. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may also use and disclose protected health information to tell you about health-related benefits or services that may be of interest to you. In some cases the Hospital may receive payment for these activities. We will give you the opportunity to let us know if you no longer wish to receive this type of information.

To discuss your treatment with other people who are involved with your care [and for our hospital directory if appropriate). We may disclose your health information to a friend or family member who is involved in your care. We may also disclose your health information to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. [Unless you inform us that you do not want any information released, we may tell individuals who ask, your location in the hospital and provide a general statement of your condition.]

Research. Under certain circumstances, we may use and disclose your protected health information for medical research. All research projects, however, are subject to a special approval process. Before we use or disclose your health information for research, the project will have been approved.

As Required By Law. We will disclose your protected health information when the law requires us to do so.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ and Tissue Donation. We may use or disclose your protected health information to an organ donation bank or to other organizations that handle organ procurement to assist with organ or tissue donation and transplantation.

Military and Veterans. The protected health information of members of the United States Armed Forces and members of a foreign military authority may be disclosed as required by military command authorities.

Employers. We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. We will tell you when we make this type of disclosure.

PRIVACY NOTICE For your records only

Public Health Risks. We may disclose your protected health information for public health activities which include the prevention or control of disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of devices or products; 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; or to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. If you agree, we can provide immunization information to schools.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.

Legal Proceedings. We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.

Law Enforcement. When a law enforcement official requests your protected health information, it may be disclosed in response to a court order, subpoena, warrant, summons, or similar process. It may also be disclosed to help law enforcement identify or locate a suspect, fugitive, material witness, or missing person. We may also disclose protected health information about the victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct on the premises; or in an emergency to report a crime, the location of the crime, victims of the crime, or to identify the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may disclose your protected health information to a coroner, medical examiner, or a funeral director.

National Security and Intelligence Activities. When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. We may disclose your protected health information to certain federal officials so they may provide protection to the President, other persons, or foreign heads of state, or to conduct special investigations.

Inmates or Persons in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or a law enforcement official when it is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.

PRIVACY NOTICE

Fundraising. We may send you information as part of our fundraising activities. As you review our fundraising materials, you will see information giving you the opportunity to "opt out" of (meaning *"choose not to participate in"*) receiving fundraising materials in the future. If you notify us that you wish to opt out, as provided in the materials sent to you with that mailing, we will not send you fundraising information or mailings in the future.

OTHER USES AND DISCLOSURES:

Most uses and disclosures of psychotherapy notes require your authorization. Psychotherapy notes are a particular type of protected health information. Mental health records generally are not considered psychotherapy notes.

Your authorization is necessary if we sell your protected health information.

If we use your protected health information to communicate about a third party's product or service that encourages you to use that product or service, and, if we are paid for that communication, we will get your authorization. These communications can take various forms like mailings, email communications and telephone communications. However, we will not need your authorization to provide you information face-to-face (example, in the Hospital); to send bills or request payment for services rendered; to communicate with you about your treatment; to provide you with prescription drug refill reminders;, to communicate with you about health care issues generally; or to communicate with you about Government programs.

We will get your authorization if we use your health information for marketing.

We will sometimes notify you about our health-related products and services as part of our Hospital operations. These are not marketing communications, and your authorization is not necessary. However, if you do not wish to receive these communications, please let us know by contacting the Privacy Officer. See contact information at the end of this Notice.

CORE CHIROPRACTIC

Insurance Verification Disclosure/Agreement

As a courtesy, Core Chiropractic will verify and file my health insurance. However, the verification of insurance benefits do NOT guarantee payment for services rendered.

I understand that the information provided through the insurance verification is not a guarantee of coverage. I also understand that actual benefits are determined only when the claim is received. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient or Guardian Signature_____

Office Manager _____ Date _____

Phone: (972) 899-2258
2851 Cross Timbers Road, Suite 111, Flower Mound, Texas 75028

CORE CHIROPRACTIC

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may

be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if the results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient or Guardian Signature_____

Office Manager _____ Date _____

CORE CHIROPRACTIC

Assignment of Benefits

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Provider.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____ Date _____

Patient or Guardian Signature_____

Office Manager _____ Date _____

Phone: (972) 899-2258
2851 Cross Timbers Road, Suite 111, Flower Mound, Texas 75028

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed:

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

From: Core Chiropractic

□ To Other Persons: _____
□ No Other Persons

The information covered by this authorization includes:

□ All information (Billing, Appointments, and Records)
□ Billing Information (including but not limited to statements, insurance processing, or payments)
□ Appointments (including but not limited to appointment times and dates, cancelation, or rescheduling)
□ Medical Records (including but not limited to diagnosis, lab test results , diagnostic test results, or treatment notes)

Form of Disclosure

□ All forms
□ Verbal
□ Electronic Copy
□ Hard Copy

Expiration Date of Authorization

This authorization is effective through 12/2025 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

- I may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.
- I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.
- I have read the above and hereby authorize the Core Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient or Guardian Signature_____

Office Manager _____Date _____

Phone: (972) 899-2258
2851 Cross Timbers Road, Suite 111, Flower Mound, Texas 75028

CORE CHIROPRACTIC

Release of Medical Records

I,_____, hereby authorize the release of my medical records

From: (Doctor or Facility Name/Phone number)

_____

_____

_____

To:

Core Chiropractic

□ Fax to: 972-899-2425

□ Mail to: 2851 Cross Timbers Rd Ste 111
Flower Mound, TX 75028

Type of records to be released:

□ All Records
□ Emergency Room Visit
□ Clinic Notes
□ History and Physical
□ Other _____

□ Physical Evaluation
□ Diagnostic Testing (MRI/X-ray)
□ Operative Report/Notes
□ Consult Report

_____ _____/_____/_____
Patient Name Date of Birth

_____ _____/_____/_____
Patient or Guardian Signature Date