Waxahachie
411 E. Jefferson St.
Waxahachie, TX 75165
P: 972-923-2440
F: 972-923-2445

HOPE HEALTH

COMPREHENSIVE HEALTHCARE FOR EVERYONE

www.hopehealthtx.org

Ennis
805 W. Lampasas St.
Ennis, TX 75119
P: 972-923-2440
F: 972-923-2445

Welcome to Hope Health!

Hope Health welcomes new patients daily. The first step to becoming a Hope Health patient is to complete the necessary forms. Completed registration forms can be submitted via: in person at our Waxahachie or Ennis locations, emailed to info@hopehealthtx.org or faxed to 972-923-2445.

Services offered at Hope Health

· ***Family Medicine***	· ***Pediatrics***	· ***Women's Health***
· ***Behavioral Health***	· ***Psychiatry***	· ***Dental (Adult & Pediatrics)***
· ***Lab Work***	· ***Diabetes Education***	· ***Outreach & Enrollment***

Please provide the following documentation, as applicable, with your completed registration form.

Photo I.D. (**a Photo I.D. is required for all patients, please provide one of the following**)

- Driver's License
- State Identification (I.D.) card
- Military I.D.
- Passport
- School I.D. (under 18yrs. old)
- Permanent Resident Card
- Certificate of Citizenship
- Certificate of Naturalization

Insured Patients (Medicaid/Medicare/Private Insurance)

- Current insurance card - we need to make a copy of the front and back of your card at *each visit*.

Proof of Income: Patients may be eligible for discounted services on a Sliding Fee Scale based on household size and income. If you qualify, you will pay a discounted amount for your care at Hope Health. ***If you wish to be considered for the Sliding Fee Scale, you must submit proof of income. Please see the following guidelines.***

- Tax Return (most recent) **or** Pay Stubs (equivalent to one month)

Weekly = 4 pay stubs	Bi-weekly = 2 pay stubs	Semi-Monthly = 2 pay stubs	Monthly = 1 pay stub

Additional Income (required if applicable):

- Social Security Income
- Alimony
- Disability Income
- Child Support
- Food Stamps (SNAP) Approval Form

Dependents (dependents are only counted if you provide one of the following):

- Tax Return (most recent) with dependent(s) listed
- Birth Certificate
- Marriage License
- Adoption Papers
- Proof of Legal Guardianship

The above referenced documentation is required to qualify for the sliding fee discount program. Medical, Dental, Behavioral Health and Labs have separate sliding fee discounts.

Each patient will be expected to pay for service at the time of the appointment. Fees or co-pays may vary depending on service(s).

If you have any questions relating to expected charges, you may inquire with the front desk personnel at the time of your visit.

PATIENT REGISTRATION FORM

All information is strictly confidential

SECTION I: PATIENT INFORMATION *(please print in all sections of the document)*

Last Name:	First Name:	Middle Initial:	Suffix:
Street Address:	City:		Zip:
County:	DOB (mm/dd/yy):	Social Security Number:	
Cell/Primary Phone:	May we leave a message? ☐ Yes ☐ No	Would you like to receive text messages? ☐ Yes ☐ No	
Work Phone:	May we leave a message? ☐ Yes ☐ No	Alternate Phone:	
Email:	Preferred method of contact: ☐ Phone ☐ Text Message ☐ Email ☐ Patient Portal		

Is the Patient a minor (under 18 yrs. old)? ☐ Yes, **if yes*, complete Section II*** ☐ No, **if no, skip Section II**
(*note: If the Patient is under 18 yrs. old and is emancipated by the court, skip to Section III. Legal documentation is required)*

SECTION II: PARENT/GUARDIAN INFO *(complete this section **only if the patient is a minor, under 18 yrs. old**)*

Custodial Parent or Legal Guardian (REQUIRED)

Last Name:	First Name:	DOB (mm/dd/yy):	
Street Address:	City:	Zip:	County:
Cell/Primary Phone:	May we leave a message? ☐ Yes ☐ No	Social Security Number:	

Relationship to Patient: ☐ Custodial Parent ☐ Legal Guardian *(if patient is under Legal Guardianship, legal documentation is required)*

Non-Custodial Parent (if applicable)

Last Name:	First Name:	DOB (mm/dd/yy):	
Street Address:	City:	Zip:	County:
Cell/Primary Phone:	May we leave a message? ☐ Yes ☐ No	Social Security Number:	

SECTION III: PATIENT DEMOGRAPHICS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Choose not to disclose

Name of Spouse/Partner (if applicable): **Spouse/Partner's Phone:**

Current Gender: ☐ Female ☐ Male ☐ Undifferentiated ☐ Unknown

Gender Identity:

☐ Female ☐ Male ☐ Genderqueer, neither exclusively Male nor Female ☐ Female-to-Male (FTM)Transgender Male/Trans Man

☐ Male-to-Female (MTF)Transgender Female/Trans Woman ☐ Choose not to disclose

☐ Additional gender category or something else, please describe: _____

Sexual Orientation:

☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Unknown ☐ Choose not to disclose

☐ Something else, please describe: _____

Preferred Pronoun: ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other ☐ Choose not to disclose

Homeless Status: ☐ Not Homeless ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown/Unreported

Race (please check all that apply)

☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Samoan ☐ Other Pacific Islander

☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Black/African American ☐ White ☐ American Indian/Alaska Native

☐ Other Asian ☐ More than one race ☐ Choose not to disclose

Ethnicity:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Hispanic or Latino/a ☐ Cuban ☐ Not Hispanic or Latino/a

☐ Unknown ☐ Choose not to disclose

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

Preferred Language (example: English, Spanish): _____ **Do you need a translator?** ☐ Yes ☐ No

Migrant Worker Status: ☐ Migrant ☐ Not a Farm Worker ☐ Seasonal **Are you a Veteran?** ☐ Yes ☐ No

SECTION IV: FINANCIALLY RESPONSIBLE PARTY (GUARANTOR)

Name of person financially responsible for patient: Relationship: ☐ Self ☐ Parent/Guardian ☐ Spouse

Street Address: City: Zip:

DOB (mm/dd/yy): Primary Phone: Social Security Number:

SECTION V: INSURANCE INFORMATION

Do You Have Insurance? ☐ Yes ☐ No ☐ Unsure **If you answered Yes, please check & complete all that apply:**

☐ Private

Name of Insurance Company: _____Subscriber's Name _____DOB_____

☐ Secondary Private

Name of Insurance Company: _____Subscriber's Name _____DOB_____

☐ Medicare

Medicare Number: _____ Do you have Medicare Secondary Insurance? ☐ Yes ☐ No

If yes, Medicare Secondary Insurance Name: _____ Medicare Secondary Policy #: _____

☐ Medicaid

Medicaid Plan: _____ Medicaid Number: _____

SECTION VI: EMERGENCY CONTACT INFORMATION *(at least one emergency contact is required)*

Name of a friend or relative:	Relationship:	Phone:
Name of a friend or relative:	Relationship:	Phone:

SECTION VII: REASON FOR VISIT

Please describe the reason for your visit: _____

_____

Are you pregnant? ☐ Yes ☐ No

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Ellis County Coalition for Health Options, dba Hope Health, for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

PATIENT SIGNATURE

_____ _____

Patient *or* Parent/Guardian Signature (if patient is under 18 years old) **Date**

PATIENT INCOME INFORMATION

All information is strictly confidential

Hope Health is a Federally Qualified Health Center (FQHC) and can offer discounted services to patients based upon financial ability or inability to pay. This program requires us to obtain income and household information from each patient for whom we provide services. If you qualify, you will pay a discounted amount for your care at Hope Health.

If you wish to be considered for the Sliding Fee Scale, please complete Section I-III of this form in its entirety. Failure to submit all the required information, will delay in the determination of discounted services. *(note: some sections may be repeated in comparison to the Patient Registration Form, please continue to complete the form out entirely)*

If you do **not** wish to be considered for the Sliding Fee Scale, please acknowledge by checking the box below and providing your signature. Patients declining to be considered for the Sliding Fee Scale do not need to submit income and household information. In addition, you may skip the remainder of the Patient Income Information form.

☐ I do **not** wish to be considered for the Sliding Fee Scale and I understand services will be priced using customary fees.

_____ _____

Patient *or* Parent/Guardian Signature (if patient is under 18 yrs. old) **Date**

SECTION I: HEAD OF HOUSEHOLD *(please print in all sections of the document)*

Last Name:	First Name:	Middle Initial:	# of Dependents:
Street Address:	City:	Zip:	County:
Date of Birth:	Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

SECTION II: INCOME *(please complete for each adult household member who is employed or has any source of income)*

Employed Person	Company Name	Gross Income (before taxes)	Paid How Often (check one)
			☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
			☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
			☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
			☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Other Sources of Income

Child Support $	Alimony $	Unemployment $	Disability $
Pension/Retirement $	TANF $	Social Security $	Other $

Health insurance coverage: ☐ Medicaid ☐ CHIP ☐ Medicare ☐ Private Insurance ☐ None

SECTION III: MEMBERS OF THE HOUSEHOLD *(list all individuals in household, including the Head of Household first)*

Name (First, Middle, Last)	Date of Birth	Age	Name (First, Middle, Last)	Date of Birth	Age
1.			5.		
2.			6.		
3.			7.		
4.			8.		

By signing below, I agree that the Hope Health staff may contact each employer listed and/or other agencies to confirm my income. I will provide Hope Health with proof of income for the purpose of calculating my discount, if I qualify. I will be asked to document my income regularly (annually if tax return is provided/monthly if paystubs or insurance is provided), and I agree to inform Hope Health if there are any changes to income, household size, or insurance coverage indicated above. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I have provided is complete and correct to the best of my ability.

_____ _____

Patient *or* Parent/Guardian Signature (if patient is under 18 yrs. old) **Date**

OFFICE USE ONLY

Date Received:	**Patient Chart #**	**Employee's Initials:**
Sliding Scale: ☐ A ☐ B ☐ C ☐ D ☐ No Income ☐ Full Cost	☐ Medicaid ☐ CHIP ☐ Medicare ☐ Private Ins. ☐ E.C. Indigent	
Type of Income Provided:	**Eligibility: From** **To:**	**Patient Notified of Fee** ☐ Yes ☐ No

Medical Records Release Form

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION *(please print in all sections of the document)*	
Patient Name:	Previous Name(s):
Date of Birth:	Social Security:
Address:	City/State/Zip:
Phone:	Email:

MY AUTHORIZATION

I voluntarily consent to and authorize Hope Health to:

Check one: ☐ **Release My Health Care Information To:** ☐ **Obtain My Health Care Information From:**

(Note: if the patient is requesting a copy of their own medical records, check "Release My Health Care Information To" and write in patient's personal information below)

Name or Organization:	Phone:
Address:	City/State/Zip:

PURPOSE *(I authorize the release of my health information for the following purpose)*

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

INFORMATION TO BE DISCLOSED

☐ **All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, and any treatment received by me.**

☐ **Dental Records:**

☐ **Only the following records or types of health information** *(list below):*

_____

TERM *(I understand that this authorization will remain in effect based on the selection below)*

☐ **From the date of this Authorization until the** _____ day of _____, 20_____

☐ **Until the Provider fulfills this request**

☐ **Until the following event occurs:** _____

REDISCLOSURE

I understand that Hope Health cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

REFUSAL TO SIGN/RIGHT TO REVOKE

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Hope Health. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Hope Health. The revocation will be effective immediately upon Hope Health's receipt of my written notice, except that the revocation will not have any effect on any action taken by Hope Health in reliance on this Authorization before it received my written notice of revocation.

QUESTIONS

I may contact Hope Health for answers to my questions about the privacy of my health information by telephone at ***(972) 923-2440***, email at ***info@hopehealthtx.org*** or in person at the Waxahachie or Ennis location

SPECIFIC AUTHORIZATIONS

Sexually Transmitted Disease (STD) as defined by law, includes Herpes, Herpes Simplex Virus, Human Papilloma Virus, Condyloma (genital warts), Chlamydia, Non-specific Urethritis, Syphilis, VDRL, Chancroid, Lymphogranuloma Venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

☐ **Yes** ☐ **No** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ **Yes** ☐ **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

FEES

Hope Health strongly encourages the receipt of medical records through fax/email to prevent fees associated with printing. If medical records are released directly to the patient in the form of a paper copy, a fee of $10.00 for the first 20 pages and $0.20 for each additional page will be charged.

REQUIRED SIGNATURES

_____	_____	_____
Patient Name (please print)	Signature of Patient	Date

If patient is unable to sign this authorization, please complete the information below:

_____	_____	_____
Name of Guardian/Representative	Legal Relationship	Signature

INTERNAL USE ONLY

This section is to be completed by the Hope Health employee who verifies the identity of the Patient, Guardian or Representative signing this form.

_____	_____	_____
Name of Witness (please print)	Signature	Date

PATIENT ACKNOWLEDGEMENT

Acknowledgement of Receipt of the Notice of Privacy Practices

This notice describes how health information about me may be used and disclosed and how I can get access to this information. Copies of our Notice of Privacy Practices may be found on our website, ***www.hopehealthtx.org***, under the Patient Information Section. You may also review this Notice in our patient lobbies, or ask for a printed copy at the front desk. I hereby acknowledge that I have reviewed a copy of the Hope Health Notice of Privacy Practice.

Initial _____

Acknowledgement of Review of Patient's Rights and Responsibilities

This notice describes the patient responsibilities to Hope Health. I agree to all the conditions as described in the Patient's Rights and Responsibilities. If I have further questions regarding the Patient Rights and Responsibilities, I may direct them to the clinic staff.

Initial _____

Acknowledgment of Review of Zero Tolerance Notice

This notice is listed within the Patient's Rights and Responsibilities. It describes the patient's responsibility to treat Hope Health staff and patients with courtesy and respect. I hereby acknowledge that Hope Health maintains a zero-tolerance policy of abuse, harassment, or violence of any kind.

Initial _____

Consent for Treatment

I hereby and voluntarily consent to authorize the clinic's Providers to provide health care services to me at the clinic. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the clinic's healthcare Providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations). A person who signs a general consent for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical test or procedures to determine HIV infection, antibodies to HIV, or infections with any other probably causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect. I understand that I will be asked to sign a separate informed general consent for vaccines administered to me and that I will be asked to sign a separate informed consent for the influenza (flu) vaccine. I understand that there is a separate consent form that I may be asked to sign for procedures performed in the office. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and remains in effect as long as I am a patient of the clinic, until I withdraw my consent, or until the clinic changes its services and asks me to complete a new consent form.

Initial _____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patient to pay at EACH Visit. If proof of income is provided, you may qualify to use our sliding fee scale for services that are not covered by your insurance or for charges that are applied to your deductible. This does not apply to charges that require a co-pay or co-insurance payment determined by your Insurance Company. Thank you for your cooperation in this matter.

Initial _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you do not cancel 24-hours prior to your appointment it will be considered a missed appointment. If you miss three (3) consecutive appointments, you may be discharged from care. The clinic will notify you in writing, via certified mail, if you are discharged from care.

Initial _____

Cash-Pay Patients

I do not have health insurance and will be responsible for services rendered at Hope Health. I agree to pay the full and entire amount for treatment given to me or to the below named patient on the date services are rendered. I also understand that I will be considered as a "full-cost" patient if proof of income is not provided or if my income is above 200% of the Federal Poverty Level Guidelines.

Initial _____

(write n/a if not cash pay)

Authorization to Release Information

Initial _____ I hereby authorize any Hope Health staff or providers to engage in any verbal or written communication to the person(s) listed below regarding my medical history, medical records, appointments and/or information pertaining to my account and/or billing history with Hope Health. I understand that if I do not list any names that family members and/or friends will not be told any information regarding my visit(s) with Hope Health.

.

_____ _____ _____
Name **Relationship** **Date**

_____ May we leave a message? ☐ Yes ☐ No
Phone Number

_____ _____ _____
Name **Relationship** **Date**

_____ May we leave a message? ☐ Yes ☐ No
Phone Number

_____ _____ _____
Name **Relationship** **Date**

_____ May we leave a message? ☐ Yes ☐ No
Phone Number

Initial _____ I further authorize Hope Health to release to agencies that I am being referred to, any information acquired in the course of my or the below named patient's examination and treatment as needed.

Initial _____ I have read and understand the above information, and I agree to the terms described. I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I certify that I am authorized by law to agree to these conditions of treatment on behalf of the patient.

_____ _____
Patient Name (please print) Date

_____
Patient Signature

_____ _____
Parent or Legal Guardian Name (please print) Parent or Legal Guardian Signature
if patient is under 18 yrs. old

_____ _____
Guarantor Name (please print) Guarantor Signature
if Guarantor is not the patient or parent

PATIENT RIGHTS AND RESPONSIBILITIES

As A Hope Health patient YOU HAVE THE RIGHT:

- **TO BE TREATED WITH RESPECT AND DIGNITY** regardless of income, race, color, national origin, sex, marital status, height, weight, arrest record, handicap or other grounds as applicable under federal, state, and local laws and/or regulations.
- **TO BE TREATED WITH COURTESY** in a culturally sensitive way by all Hope Health Staff.
- **TO EXPECT THAT ALL COMMUNICATIONS AND RECORDS** pertaining to your health will be treated as confidential and safe guarded.
- **TO RECEIVE A COPY OF THE PATIENT PRIVACY NOTICE** describing our privacy practices and the ways that we use, disclose and safeguard your patient information.
- **TO ACCESSS YOUR HEALTH RECORDS**. Both state and federal law give you the right to access your medical record and billing information. These laws also allow disclosure of your information to legally authorized representatives.
- **TO HAVE INTERVIEWS, EXAMINATIONS AND TREATMENT CONDUCTED IN PRIVATE**. Unless requested by you, people accompanying you will have to wait in the waiting area for you.
- **TO RECEIVE THE BEST POSSIBLE CARE** and have options for care explained to you.
- **TO RECEIVE CARE IN AN ENVIRONMENT COMMITTED TO PATIENT SAFETY**.
- **TO REFUSE TREATMENT** to the extent permitted by applicable laws and regulations after being informed of the risks and potential consequences of refusing such recommended care. You are responsible for the outcome of refusing treatment.
- **TO REQUEST AND RECEIVE AN EXPLANATION OF YOUR CLINIC BILL.** You must pay or arrange to pay all agreed fees; if you cannot pay right away, please contact our billing office so that we can continue to provide care for you as we work out a budget payment plan.
- **TO RECEIVE CARE REGARDLESS OF INABILITY TO PAY**. You will not be denied services because of inability to pay.
- **TO REQUEST AND BE PROVIDED WITH LANGUAGE ASSISTANCE** if you are not fluent in English or if you are hearing impaired. You have a right to information and explanations in the language you normally speak and in words that you understand.
- **TO RECEIVE INFORMATION REGARDING "ADVANCE DIRECTIVES"** (End of Life Care).
- **TO GIVE YOUR CONSENT FOR SERVICES** provided at Hope Health.
- **TO BE HEARD IF PROBLEMS, COMPLAINTS OR CONCERNS ARISE.** You may request to speak to a member of the Management Team in person or by calling 972-923-2440.

As a Hope Health patient YOU HAVE A RESPONSIBILITY:

- **TO BE ON TIME** for your appointment.
- **TO GIVE HOPE HEALTH STAFF ACCURATE INFORMATION** about your present financial status and/or any changes in your financial status.
- **TO PAY, OR ARRANGE TO PAY, FOR SERVICES RENDERED**, including any charges not covered by your insurance.
- **TO COME TO YOUR APPOINTMENT WITH A CUSTODIAL PARENT/LEGAL GUARDIAN**, if you are a minor.
- **TO CALL IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT**. Please call at least 24 hours in advance if you are unable to keep an appointment.
- **TO PROVIDE HOPE HEALTH WITH CURRENT INFORMATION** on your insurance, address, name and phone number.
- **TO PROVIDE YOUR HEALTH HISTORY, CURRENT MEDICATION LIST, AND ALLERGIES**.
- **TO ASK QUESTIONS** regarding your diagnosis or treatment for clear understanding. Advise staff if you do not understand any aspect of your treatment.
- **TO FOLLOW THE TREATMENT PLAN OR THE PROVIDER'S RECOMMENDATIONS AND ADVICE**.
- **TO TELL US ABOUT UNEXPECTED COMMPLICATIONS** that may happen during the course of your treatment.
- **TO BE CONSIDERATE OF OTHER PATIENTS' RIGHTS AND PRIVACY**.
- **TO TREAT HOPE HEALTH STAFF WITH COURTESY AND RESPECT.** Hope Health maintains a zero tolerance policy of abuse, harassment or violence of any kind.
- **TO KEEP HOPE HEALTH A SAFE PLACE FOR YOU AND OTHERS.** What you can do to keep it safe: refrain from behaviors such as, but not limited to, profanity, name-calling, racial slurs or other disrespectful comments, yelling, aggressive behavior, physical contact, or being intoxicated or under the influence of drugs while on Hope Health properties.

Revised 8.2022

HOPE HEALTH
NOTICE OF PRIVACY PRACTICES
hopehealthtx.org

411 E Jefferson, Waxahachie, TX 75165
805 W Lampasas, Ennis, TX 75119
Contact our Privacy Officer: 972-923-2440
Detailed Notice on website and in clinics.

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them.*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them.*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures.*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- *We are required by law to maintain the privacy and security of your protected health information.*
- *We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.*
- *We must follow the duties and privacy practices described in this notice and give you a copy of it.*
- *We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.*

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site:

www.hopehealthtx.org

You may contact our Privacy Officer at 972-923-2440.

8 / 2022