Dear Valued Patient,

On behalf of the physicians, associate practitioners, nurses and staff of USMD Physician Services, I want to welcome you to our organization and thank you for choosing a USMD physician to care for you and/or your loved ones.

At USMD, our physicians put their patients' needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

With nearly 70 locations and more than 250 physicians and associate practitioners in just under 20 different specialties, USMD offers convenient locations all across the Dallas-Fort Worth metroplex to care for everyone in your family at every stage of life.

One of the unique features that USMD offers is NextMD for MCNT patients and Follow My Health for UANT patients. Through NextMD and Follow My Health, patients have communication with their physician's office through a protected, online portal. NextMD and Follow My Health also give patients the ability to access and review lab results and request appointments and prescription refills. Please talk with a staff member if you have questions or would like more information.

To learn more about USMD, please visit our website at www.usmd.com.

Again, thank you for choosing USMD for your healthcare needs.

Sincerely,

Richard C. Johnston MD, FACP
Chief Executive Officer and Chief Physician Officer
USMD Health System

USMD Health System

PEDIATRIC NEW PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS # (optional): _____

Main Contact:

Parent/Guardian Name: _____ Relationship: _____

Occupation:_____ Home Phone #:_____ Work Phone #: _____

Parent/Guardian Name: _____ Relationship: _____

Occupation:_____ Home Phone #:_____ Work Phone #: _____

○ Divorced ○ Separated

Are there any special custody arrangements we should be aware of ? ○ Yes ○ No

Siblings:_____ DOB: _____/_____/_____ Other Siblings:_____ DOB: _____/_____/_____

If Yes, please describe: _____

_____

_____

Living Arrangements: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

OTHER PATIENT INFORMATION

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____(Please Specify)

USMD Health System

PEDIATRIC NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ /_____ / _____

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID # _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID #: _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

USMD Health System

GENERAL CONSENT FORM

Patient Name: _____ **Date of Birth:** _____ /_____ /_____

Assignment of Benefits. I authorize USMD Physician Services, ("USMD") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that USMD will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for USMD to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, USMD may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at USMD's expense.

Patient Initials: _____

Electronic Prescription. I understand USMD utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize USMD, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize USMD to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #: _____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)

I consent for USMD to photograph the minor patient for identification purposes only. **Patient Initials:** _____

_____

Print Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

USMD Health System

FINANCIAL POLICY

Patient Name: _____ Patient Date of Birth:_____/_____/_____

Please read prior to receiving services.

USMD Physician Services ("USMD") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, USMD will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **MEDICARE:** USMD providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of USMD.

USMD Health System

FINANCIAL POLICY

- **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 514-5200**.

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 514-5200.

USMD Health System

PATIENT HISTORY (PEDIATRIC)

Today's Date: _____

Patient's Name (First, Middle, Last): _____

Date of Birth: _____/_____/_____ Race: _____ ☐ Male ☐ Female

Primary Care Physician: _____

Reason For Visit: _____

PAST SURGERIES (include all surgery in your lifetime) or ☐ **NONE**

Type of Surgery	Date (approximate)	Hospital or City if known

Pharmacy: _____ Phone: _____

CURRENT MEDICATIONS (include prescription, over the counter, and herbal medications) or ☐ **NONE**

Name of Medication	Dose (mg)	How often is the medication taken	Reason for taking medication	Physician prescribing

MEDICAL HISTORY

High Blood Pressure	☐ Yes ☐ No ☐ Family		Ulcers	☐ Yes ☐ No ☐ Family	
High Cholesterol	☐ Yes ☐ No ☐ Family		Emphysema	☐ Yes ☐ No ☐ Family	
Heart Attack	☐ Yes ☐ No ☐ Family		Stroke	☐ Yes ☐ No ☐ Family	
Mitral Valve Prolapse	☐ Yes ☐ No ☐ Family		Asthma	☐ Yes ☐ No ☐ Family	
History Kidney Stones	☐ Yes ☐ No ☐ Family		Diabetes	☐ Yes ☐ No ☐ Family	
Cancer	☐ Yes ☐ No ☐ Family		Hearing Problems	☐ Yes ☐ No ☐ Family	
Urinary Tract Infections	☐ Yes ☐ No ☐ Family		ADD or ADHD	☐ Yes ☐ No ☐ Family	
Down Syndrome	☐ Yes ☐ No ☐ Family		Spina Bifida	☐ Yes ☐ No ☐ Family	
Autism	☐ Yes ☐ No ☐ Family		Cerebral Palsy	☐ Yes ☐ No ☐ Family	

SOCIAL HISTORY

Is patient adopted? ☐ Yes ☐ No Foster Child? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No If yes, how much? _____

Caffeine use: ☐ Yes ☐ No If yes, how much? _____

Tobacco use: ☐ Yes ☐ No If yes, how much? _____

USMD Health System

PATIENT HISTORY (PEDIATRIC)

Patient Name: _____ Date of Birth: _____ /_____ / _____

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Weight changes	☐ Yes	☐ No

Current weight _____

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Allergic/Immunologic

Hay fever	☐ Yes	☐ No
Drug allergies	☐ Yes	☐ No

Drug name: _____

Immunizations current?	☐ Yes	☐ No

Neurological

Dizzy spells	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/sluggish	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Integumentary

Skin rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent itch	☐ Yes	☐ No

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No

Current height _____

Ear/Nose/Throat/Mouth

Ear infection	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Hematologic/Lymphatic

Swollen glands	☐ Yes	☐ No
Blood clotting problems	☐ Yes	☐ No

Genitourinary

Urinary frequency	☐ Yes	☐ No

Nighttime urination _____

Daytime urination _____

Painful urination	☐ Yes	☐ No
Urinary urgency	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Straining to urinate	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Do you leak urine?	☐ Yes	☐ No

Patient Name: _____ Date: _____

Form Completed by: _____ Signature: _____

(Parent or Guardian) (Parent or Guardian)

USMD Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO USMD PHYSICIAN SERVICES

Name of Patient: _____ D.O.B._____ Age:_____
LAST FIRST M.I.

I, _____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically or orally to USMD Physician Services:

Address: _____

_____

Phone: _____

Fax: _____

Information is for:

☐ Dr. _____

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. USMD Physician Services, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness Signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual Date

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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER AT 214.493.4000.

This Notice of Privacy Practices describes how Medical Clinic of North Texas PLLC, d/b/a USMD Physician Services, ("USMD") may use and disclose your protected health information ("PHI") to carry out your treatment, payment for your health care, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services. We are required to maintain the privacy of PHI and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our Notice at any time. The new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, www.USMD.com, or by calling your USMD physician office and requesting that a copy be sent to you in the mail or asking for one at the time of your next appointment. A copy will also be posted in the office.

1. Uses and Disclosures of PHI

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. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of USMD. Following are some examples of the types of uses and disclosures of your PHI that USMD is permitted to make.

TREATMENT: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to physicians who may be treating you or who become involved in your care.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your PHI in order to support the professional and business activities of USMD. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and nursing students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical and nursing school students that see patients at USMD. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and provide other requested information. We may also call you by name in the waiting room when you are ready to be seen. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We will share your PHI with a Business Associate or Business Associate sub-contractor, or any affiliate of USMD with whom we share information; to perform various activities (e.g., billing, transcription services, telephone answering services, etc.) for USMD. We may use or disclose your PHI, as necessary, to provide you with appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of PHI Based upon Your Written Authorization.
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or USMD has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object.
You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician or USMD may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Unless you object, USMD may decide to provide a copy of your PHI to your treating physician, departing USMD, for the purpose of continuity of care.

OTHERS INVOLVED IN YOUR HEALTHCARE: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI 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 PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

EMERGENCIES: We may use or disclose your PHI in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object.
We may use or disclose your PHI in the following situations without your authorization. These situations include:

REQUIRED BY LAW: We may use or disclose your PHI to the extent that the use or disclosure is 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. You may be notified, as required by law, of any such uses or disclosures.

BREACH NOTIFICATION: We will notify affected individuals of a breach of unsecured PHI.

PUBLIC HEALTH: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

COMMUNICABLE DISEASES: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

FOOD AND DRUG ADMINISTRATION: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

RESEARCH: If you choose to participate in medical or scientific research, we may disclose your PHI 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 PHI.

HEALTH OVERSIGHT: We may disclose PHI 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.

ABUSE OR NEGLECT: We may disclose your PHI to a public health authority that is authorized by law to receive reports of abuse or neglect. We may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

LEGAL PROCEEDINGS: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

LAW ENFORCEMENT: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of USMD, and (6) medical emergency (not on USMD premises) and it is likely that a crime has occurred.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: We may disclose PHI 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. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

WORKERS' COMPENSATION: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

MILITARY ACTIVITY AND NATIONAL SECURITY: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

INMATES: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

REQUIRED USES AND DISCLOSURES: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

SPECIAL CIRCUMSTANCES: Alcohol and drug abuse and certain infectious disease information have special privacy protections. USMD will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse or certain infectious disease treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or, as required by law.

FUNDRAISING/MARKETING: USMD will not use your PHI for fundraising or marketing purposes or sell your PHI without your written permission.

2. Your Rights

The following uses and disclosures will only be made with your written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) Other than face-to-face conversations about services and treatment alternatives we will not use your protected information for third party marketing purposes without your authorization; (iii) disclosures that constitute a sale of PHI; (iv) other uses and disclosures not described in the Notice of Privacy Practices.

Right to Access and Notice of Electronic Health Records under Texas Law. You are hereby notified that USMD maintains an electronic health record system for your records. You may submit a written request to USMD for a copy of your electronic health records which will be provided to you electronically within 15 days unless you agree to accept your records in another form. Under limited circumstances, your request may be denied.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of your health record, as provided by law. The request must be made in writing.

You have the right to request a restriction of your PHI. You have the right to restrict disclosure of PHI to a health plan where you paid out-of-pocket, in full, for the care or service provided. You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. We are not required to agree to a restriction that you may request.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your PHI. This means you may request, in writing, an amendment of your health record as provided by law, for the purpose of correcting an error or misinformation. You will be notified if the request cannot be granted.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI, as provided by law. This request, made in writing, excludes disclosures we may have made to you or others involved in your care, or for notification purposes to legal or regulatory agencies. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Questions or Complaints

If you have a question or complaint about your privacy rights, please contact the USMD Privacy Officer via phone at **214.493.4000** or via mail at 6333 North State Highway 161, Suite 200, Irving, TX 75038. Should the Privacy Officer be unable to resolve your complaint to your satisfaction, you may file a complaint with the U.S. Department of Health & 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.

This notice became effective on February 19, 2016.