Patient Name: _____ Date: ____/____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

Please include any additional information you wish about the above answers. Thank you.

Northwest Anesthesiology and Pain Services, PA

EVOLUTION PAIN AN...

HIPAA DISCLOSURE:
PATIENT CONTACT & VERBAL RELEASE OF INFO CONSENTS

Patient Name (*print*): _____ DOB: _____

A) RELEASE OF PATIENT INFORMATION CONSENT

Consent to Verbally Release

I hereby give consent to release my personal health information either verbally or in writing to my family, friends, or others for purposes of obtaining treatment and/or for payment of medical services.

In that regard, Evolution Pain and Spine, a provider for Northwest Anesthesiology and Pain Services, PA, has my permission to release my confidential personal health information to the following family members, friends, or other individuals who are involved in my care:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this authorization, at any time by providing written notice to this office. The revocation will take place on the date of the written notice and cannot be applied to prior disclosures.

A) AUTHORIZATION TO COMMUNICATE/LEAVE MESSAGES

From time to time it may be necessary for representatives of Northwest Anesthesiology and Pain Services, PA to leave messages for patients on their home or cellular phone. The purpose of these messages may be to return patient calls, remind patients that they have an appointment, to notify patients that the medical staff would like to discuss lab or procedure results, or to ask a patient to call one of the clinics of Northwest Anesthesiology and Pain Services, PA regarding an issue or concern. At no time will a representative of Northwest Anesthesiology and Pain Services, PA discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with your household members, your answering machine and/or on your voicemail. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial: _____ Consent to leave message with HOUSEHOLD MEMBERS (at phone numbers you have provided in record)

Initial: _____ Consent to leave message on HOME ANSWERING MACHINE (to phone numbers you have provided in record)

Initial: _____ Consent to leave message on VOICEMAIL and/or TEXT MESSAGING/SMS (to phone numbers you have provided in record)

_____ _____

Patient Signature Date

Evolution Pain and Spine,
3725 East League City Pkwy, Suite 240
League City, TX 77573
T (281) 916-1012
F (281) 916-1073

Northwest
Anesthesiology and
Pain Services, PA

EVOLUTION
PAIN

Code of Conduct

We are glad that you have chosen Evolution Pain and Spine as your new pain management provider. Our providers strive to improve your quality of life through medication management and interventional pain therapies.

Listed below are reasons our group may consider as grounds for patient termination from the practice. This are inclusive, but not limited to the following:

- ✓ Disruptive, uncooperative, or disrespectful behavior towards our staff either in-person or via telephone conversation (Please Note: this will include relatives and non-relatives of the patient)
- ✓ Repeated No Shows, Cancellations, and Late arrivals. Patients are required to provide notification to office staff 24-hours prior to the scheduled appointment of any reason they are not able to keep the original appointment date or time.
- ✓ Refusing to adhere to your provider's plan of care
- ✓ Violating your medication and controlled substances agreement.
- ✓ Failure to pay for services rendered. (Please Note: for any questions regarding outstanding balances, call the billing department at 832-698-5320 for assistance.)
- ✓ You, the patient, terminates the relationship with Evolution Pain and Spine, a provider of Northwest Anesthesiology and Pain Services, PA.

Message Regarding Social Media Reviews/Postings:

You have the right to publish reviews via social media (Facebook, Yelp, Google, etc...) regarding your experience with Northwest Anesthesiology and Pain Services, PA and Evolution Pain and Spine. However, if a negative review is published before allowing us to rectify or resolve the situation, you grant us permission to review and/or request the negative comment to be removed from the site. Violation of these policies may be considered for patient termination at your provider's discretion.

Printed Name: _____ **Date:** _____

Signature: _____

Evolution Pain and Spine,
3725 East League City Pkwy, Suite 240
League City, TX 77573
T (281) 916-1012
F (281) 916-1073

Northwest
Anesthesiology and
Pain Services, PA

Medication History Consent Form

Name:	DOB:	Date:

On behalf of Northwest Anesthesiology & Pain Services, PA my provider: Dr. Sunil Thomas has educated me regarding medication that has been prescribed to me regarding the benefits and possible side effects of this medication, possible drug, and/or food interactions that may occur while taking this medication, and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

I also provide consent to my prescriber to have access to my past prescription history.

Patient Signature: _____ Date: _____

- It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor **BEFORE** taking any medication.
- It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report **IMMEDIATELY** to a health care provider
- It is recommended that any provider prescribing medications to obtain a thorough patient history that should include (but not limited to):
    1. What medication including prescribed over-the-counter medications, the patient is or has been taking
    2. What food and drug allergies the patient has
    3. What medical conditions the patient has
- Patient (or guardian) has verbalized understanding of medication education

Northwest Anesthesiology and Pain Services, PA

Legal Assignment of Benefits and Designation of Authorized Representative

Patient Name: _____

DOB: _____

Social SecurityNumber: _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider group, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider group, to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or other insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Patient Signature Date

Northwest Anesthesiology and Pain Services, PA

OFFICE AND FINANCIAL POLICIES

Initial:____ **Insurance:** If a referral from your primary care physician is required for your visit, it is your responsibility to obtain it. As a courtesy, we will attempt to obtain it on your behalf, but failure to obtain the referral would require you to reschedule your appointment, unless you choose to be seen as a self-pay patient. If you confirmed your visit with our office and arrive with no referral, a rescheduling fee (also termed "No Show Fee") may be applied because your allocated time slot was confirmed with your acknowledgement of responsibility for obtaining a referral.

Initial:____ **Forms Surcharge (at the discretion of your physician):**
Disabled Parking Applications, and Private Disability Insurance forms (No Charge).
$50.00: Family Medical Leave Act forms, Bad Check Fees, and Credit Card Deferment forms.
$150-300 (depending on complexity) for dictated letter describing medical care and limitations.

Initial:____ **Check In and Financial Policy:** Please bring your insurance card and photo ID. You are required to notify our office when your insurance policy changes. Please be prepared to pay any co-payments or co-insurances or past due balances, which we will notify you through our online portal or communication with the billing company. In the event that your plan determines a service to be "not covered", you will be responsible for the entire charge.

Initial:____ **No Shows, Late Cancellations, Procedural Cancellation and Late Arrivals:** We ask that you give us a courtesy call 24 hours in advance if you must cancel your office appointment. We will attempt to confirm your visit 24-48 hours prior to the visit. *No-showing for a confirmed appointment/procedure or canceling within the 24 hour period will result in a **$50 charge** to your account.* Arriving 15 mins past your arrival time may require a rescheduling of your appointment, so as not to inconvenience other patients. Over 30 mins late will automatically cancel your appointment for rescheduling. All late fees are subject to provider discretion.

Initial:____ **Refill Requests:** Please allow 48 hours to process all prescription refill requests. Therefore, schedule a medication refill visit >48 hours to completion of prescribed controlled substances. Prescription refill requests will not be accepted after hours or on weekends. No exceptions.

Initial:____ **Minors:** Guardian(s) accompanying patients that are minors are responsible for any financial responsibilities as well as providing current insurance information for the minor.

Initial:____ **Medical Records:** Please note that Northwest Anesthesiology and Pain Services, PA has an active contract with HealthMark Group to fulfill all medical record requests. All urgent requests/copies of your medical records can be made available upon request at a normal **charge of $25.00** *for the first 20 pages and $0.50 per page thereafter.* A medical records release must be completed and submitted to request a copy of your records.

Initial:____ **Office Based Procedures:** Office based procedure visits are not early medication refill visits and may require a copay. The medication refill visit will need to be scheduled on a separate visit date.

I have read, understand and agree to the above office and financial policies. I agree to be bound by its terms. I hereby attest that I have provided current and accurate demographic and insurance information. In addition, I authorize release of information necessary for insurance filing and precertification by signing this statement. I am herein authorizing payment of medical benefits to my provider when an assigned claim is filed.

Patient Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Northwest
Anesthesiology and
Pain Services, PA

PHYSICIAN OWNERSHIP, LAB NOTICE AND FINANCIAL DISCLOSURES

Patient Name: _____ **DOB:** _____

PATIENT DISCLOSURE:

To All New Patients:

During the course of your medical treatment with Northwest Anesthesiology and Pain Services, PA (hereinafter NWAP), Physicians of NWAP may refer you to a hospital, ambulatory surgery center, diagnostic facility, laboratory and/or implant a medical device in which they may have a pecuniary interest in the company that owns the aforementioned.

As a patient of NWAP you have a right to be treated by physicians and at facilities of your choosing. If you elect to be treated at facilities other than those to which you have been referred, this will in no way affect the quality of your healthcare. However, your treating physician may or may not be credentialed at the facilities of your choosing and thus require you to obtain a new treating physician.

As a patient of NWAP you have the right to request and you agree that you will request that NWAP refer you to different physician, hospital, ambulatory surgery center and/or diagnostic facility if you are unhappy with the initial referral.

You will receive a bill for all services performed by our physicians and our company's toxicology laboratory. Our bills are consistent with usual and customary charges in the geographic area where the services are provided and vary based on varying elements such as diagnosis addressed, type of testing required, complexity of decision making and associated work associated to the visit. Your insurance contract is an arrangement between you and your insurance carrier. When disputes occur between you and the insurance carrier, we will assist you in those disputes, but ultimately the dispute resolution is your responsibility. Our office complies with contractually regulated billing policies and procedures of your carrier, when applicable.

Patients are responsible for full payment of charges incurred during each appointment. Our staff collects payment based on the patient's insurance coverage and benefits. **All financial responsibility amounts quoted to patient are estimates and responsibility may change once insurance has processed and paid the patient's claim.**

If you assign the benefits from any insurance or third party to Northwest Anesthesiology and Pain Service, PA for medical services provided to you. NWAP has the right to decline or accept assignment of such benefits. If these benefits are not assigned to NWAP, you, the patient, agrees to forward to NWAP, upon receipt, any insurance or third-party payments received for services rendered to you.

_____ _____

Patient Signature Signature Date

Northwest Anesthesiology and Pain Services, PA

MEDICATION/OPIOID CONTRACT

I, _____, agree to the following guidelines as part of my treatment for chronic pain management with a provider from Northwest Anesthesiology & Pain Services, PA.

1. I understand the following:
   - If I have a chronic pain problem, it may require the prescription of opioid pain medications to increase my quality of life by increasing my function and reducing my pain perception. I understand that Opioid medications can also be prescribe for short term, temporary, acute pain problems. The risks, side effects, and benefits of the medication have been discussed with me in detail in the event that chronic opioid therapy is indicated. I agree to the policies set forth by Northwest Anesthesiology and Pain Services, PA in accordance to the federal and state guidelines, for toxicology monitoring and diagnostic testing needed to evaluate the risks associated with opioid treatment.
   - I understand that the use of the opioids in pain Management is an acceptable practice, however, there is a potential for habit formation and in some instances, may result in addiction.
   - If I am treated with opioid medications, I agree to take the medications only as prescribed and I will not accept a prescription for an opioid based, controlled substance, from another physician, without approval from my provider. An exception to this would be in an emergency situation, where I will notify the ER Providers of my opioid contract with Northwest Anesthesiology and Pain Services, PA.
   - I will use only one pharmacy to obtain prescribed controlled substances and any changes to this must be discussed with the provider prior to any changes. The pharmacy will be in the greater Houston area associated with the office I am being treated in, not out of the state of Texas. I give full consent for my provider and pharmacist to exchange information in writing or verbally. I also understand that changing pharmacies regularly is considered by the state and federal government as high risk behavior for drug aberrancy and I will comply with the office policy for toxicology testing when doing so.
   - I understand that opioids are not effective long term, as single therapy, due to tolerance and dependency. An opioid prescription will be used in conjuncture a with multi-modal therapeutic plan, focused on interventional treatment options. If I am prescribed opioids, the goal is to continuously reduce and/or taper me off of them. To do so, I will meet the provider regularly to assess my progress. If the provider does not feel that opioid therapy is medically indicated, then they are not obligated to continue prescribing them. This may mean procedures, intervention, and even surgery will be considered and expected as the appropriate treatment over opioid medication(s).
   - I am responsible for any lost, misplaced, stolen or miscounted medications from the pharmacy. The provider will not replace my medications or refill my medications early in the event that this occurs. I will not share my medications with anyone. A stolen medication will require a police report to be made and a notification to my provider within 48 hours of loss.
   - I agree to participate in any medical or psychological assessments recommended by my provider for assessment for dependency, aberrancy or worsening of any comorbid conditions. I also understand that I will comply with Urine Drug Testing Policies of the office, including random sampling and pill counts. Failure to show up at the allocated time for random testing would forfeit my next prescription.
   - The use of illegal drugs can lead to immediate discontinuation of opioid therapy and possible dismissal from the practice, at the discretion of the provider and practice. If toxicology testing is indicated, I will follow the protocols for toxicology testing as well as be responsible for any financial costs, if not covered by my insurance.
   - I understand that at every visit I will bring all prescription medications with me in their original containers on every appointment even if the bottle is empty. Failure may result in the rescheduling of my appointment.
   - Failure to comply with ordered procedures or test may result in the discontinuation of medications.
   - Based on the opioid medication taken, the amount, and the "time on these medications," the physician will determine the time interval for refills and re-evaluation based on state guidelines. Evaluation can only be seen 7 days prior to the medication historical refill date. Most pharmacies will only refill 5 days "earlier" to this date. Refills are processed 30-31 days since the last refill date; not from the last day seen by the physician. Lastly, it is not the physician's responsibility to refill your prescription if you are "out of town" or "on vacation"

2. I understand that my provider may stop prescribing the medications listed if:
   - I do not show any improvement in pain or my activity has not improved.
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.
   - The clinic finds that I have broken any part of this agreement.
   - My toxicology diagnostic testing reveals I am not following the recommended dosages for my prescriptions or the testing reveals I have used illegal or street drugs.
   - *My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from receiving further care from this clinic following guidelines set forth by the Texas State Medical Boards.*

SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOD MEDICATIONS:
There are potential adverse effects that may occur while working and taking opioid medications. These adverse effects could potentially be dangerous and cause safety risks. These include delayed reaction time, impaired judgement, drowsiness, and physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time.

ADVERSE EFFECTS OF MIXING OPIOID MEDICATIONS:
These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol.

- Feeling of Anxiety
- Confusion
- Dizziness /Drowsiness
- Impaired Judgment
- Slowed or Difficult Breathing
- Constipation
- Nausea
- Vomiting
- Slow Heart Rate
- Excessive Sweating
- Difficulty Urinating
- Physical/Psych Dependence

RISKS:
Abruptly stopping the medication may lead to withdrawal symptoms. The symptoms below may be harmful if you are being treated with other co-morbid conditions. Please do not stop medications without the supervision of your provider.

- Runny Nose
- Diarrhea
- Sweating
- Rapid Heart Rate
- Difficulty Sleeping for Several Days
- Abdominal Cramps
- Shakes and Chills
- Nervousness

I have read the above **MEDICATION/OPIOID CONTRACT.** By signing this contract, I affirm that I have read, understand and accept all terms of the contract and appropriate opportunity was allocated to me by the provider to answer any and all questions that I may have prior to prescribing opioids.

Patient's Signature: _____ **Date:** _____

Provider's Signature: _____ **Date:** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Evolution Pain & Spine
Address 3725 E. League City Pkwy Suite 240
City League City State TX Zip Code 77573
Phone (281) 916-1012 Fax (281) 916-1073

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ All health information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

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 X _____ _____
Signature of Minor Individual **DATE**

NOTICE OF PRIVACY PRACTICES
(Effective: November 10, 2021)
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.

Northwest Anesthesiology and Pain Services, PA

Our Responsibilities.

- We are required by law to maintain the privacy of your health care information (Protected Health Information – PHI) and to educate our personnel concerning privacy and confidentiality.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health 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 health information except as described in this notice or if you tell us in writing that we can. You may change your mind at any time by sending us written notice. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization.
- If your health information is electronically disclosed and your written authorization is required, a separate authorization will be needed for each request.
- This notice applies to all health care records created by and received at Northwest Anesthesiology and Pain Services, PA (NWA) and tells you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI.
- This notice applies to NWAP employees, contractors, students, volunteers and anyone doing business with NWAP.
- We do not create or manage a hospital directory.

Our Uses and Disclosure. Except as listed below, we will not use or disclose your health information without your written authorization.

1. **Typical Use and Disclosure of Your Health Information.** We usually use or share your information for treatment, payment and healthcare operations as defined in this Notice. NWAP shares information with its Affiliated Organizations which includes, but is not limited to, Advanced Revenue Management GP, LLC. This group of Affiliated Organizations may use and disclose your health information to provide treatment, payment, or health care operations for the Affiliated Organizations which include activities such as patient care, financial services, insurance, quality improvement, education and risk management.

- **Treatment.** We can use your health information and share it with other professionals who are treating you. For example, your physician may ask a pharmacist or referring physician about your current medications and/or care in order to treat you.
- **Payment.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **Health Care Operations.** We can use and share your health information to run our practice, improve your care, train future health care professionals and contact you when necessary. For example, we use health information about you to manage your treatment and provide quality healthcare services.

We may disclose your health information to our business associates who provide services to us to help us carry out our treatment, payment or health care operations. For example, we may disclose your information to a consultant who is helping us improve patient care.

2. **Other Cases We Use and Disclose 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: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- **Help with Public Health and Safety Issues.** We can share your health information for certain situations such as:

  √ Preventing disease
  √ Helping with product recalls
  √ Reporting adverse reactions to medications
  √ Reporting births or deaths or suspected abuse, neglect or domestic violence
  √ Preventing or reducing a serious threat to anyone's health. This includes notifying a person who may have been exposed to, or be at risk for, contracting or spreading a disease or condition to protect the public health.

- **Conducting Research.** We are very excited to advise you that we are now integrating clinical research studies into our treatment program to ensure our patients have access to the latest medical research and the most cutting edge treatments available. You will have the opportunity to participate in these new studies and clinical research programs if you so choose. (You will be required to sign a separate document agreeing to your participation) Your medical records will be reviewed by the research company to evaluate your eligibility to participate in these programs, if any. If you are eligible for a research study, your medical provider will contact you regarding how these studies may enhance your medical care. The research company will also contact you to educate you regarding what the study entails. Thereafter you will have the option to whether you wish to participate in the study or not.
- **Comply with the Law.** We will share your information if state or federal laws require it, including with the Department of Health and Human Services if it wants to verify that we are complying with federal laws.
- **Respond to Organ and Tissue Donation Requests.** We can share your health information with organ procurement organizations.
- **Medical Examiners or Funeral Directors.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' Compensation, Law Enforcement, and Other Government Requests.** We can use or share your health information:

√ For workers' compensation or similar programs that provide benefits for work- related injuries or illness.

√ For law enforcement purposes.

√ If you are a member of the armed forces, as required by military command authorities.

√ With health oversight agencies for activities authorized by law.

√ For special government functions such as intelligence, counterintelligence, and other national security activities authorized by law and presidential and foreign dignitary protective services.

- **Inmates.** We may release health information of inmates to the correctional institution or official under specific circumstances for care and safety purposes.
- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for audits, investigations, inspections and licensure and other activities necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Respond to Lawsuits and Legal Actions.** We can share your health information in response to a court or administrative order, or in response to a subpoena or discovery request.

3. **Special Protections for Certain Information.** We will not disclose or provide any information about any substance abuse treatment, genetic information, HIV/AIDs status or mental health treatment unless you provide specific written authorization or we are otherwise required by law to disclose or provide the information.

Your Choices

1. **Your Right and Choice to Tell Us To.** We can share your information as described below. Please tell us if you have a preference on how we share your information in these situations.

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Provide you with appointment reminders

If you are not able to tell us your preference, for example, 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.

2. **Other Limited Situations**

- **Treatment Alternative.** We may use and disclose your information to give you information about treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits, educational programs, or services that may be of interest to you.

3. **Cases Where We Never Share Your Information Unless You Give Us Written Authorization**

- Marketing purposes
- Sale of your health information

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. We may deny your request in certain limited circumstances; in such cases, we will notify you in writing and you may request that the denial be reviewed. Ask us how to do this.
√ We will provide a copy or a summary of your health information within 15 days of your request, provided all conditions related to release of records are met. We may charge a reasonable fee.

Ask Us to Amend Your Medical Record.

√ You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how.
√ If we agree with the request, we will make the correction and give it to those who need it and those you ask us to give it to. If we say "no" to your request we will tell you why in writing within 60 days.

Request Confidential Communications.

√ You can ask us to contact you in a specific way, such as calling your home or office phone, or sending mail to a different address. We will say "yes" to all reasonable requests.

Ask Us to Limit What We Share or Use

√ You can ask us not to use or share certain health information for treatment, payment or our operations. We can say "no" to your request. If we do agree, we will comply unless the information is needed to provide emergency treatment.

√ If you pay us 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 Have Shared Your Information

√ You can ask for a list (accounting) of the times we have shared your health information for six (6) years prior to the date you ask for it. This list will include whom we shared it with and why.
√ The first list you request within a twelve (12) month period is free, but we will charge a reasonable, cost- based fee if you ask for another list within twelve (12) months. You may choose to cancel your request before any costs are incurred.

Get a Copy of This Privacy Notice. You can ask for a copy of this Notice at any time, even if you have agreed to receive the notice electronically.

Choose Someone to Act for You.

√ If you have given someone medical power of attorney or if someone is your legal guardian with authority under state law, that person can exercise your rights and make choices about your health information when you are not capable of doing so.
√ 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 file a complaint if you feel we have violated your privacy rights by contacting:

Northwest Anesthesiology and Pain Services, PA
Office of General Counsel
311 Holderrieth Blvd.
Tomball, Texas 77375
privacycompliance@nwapservices.com

Office for Civil Rights, U.S. Department of Health & Human Services
200 Independence Avenue, S.W.,
Washington, D.C. 20201
1.877.696.6775
or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

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 offices.

Thank you for choosing Northwest Anesthesiology and Pain, Services, PA

Non-Discrimination Statement. NWAP complies with applicable **Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Northwest Anesthesiology and Pain Services, PA, provided me with a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Print Patient Name Patient DOB

_____ _____
Patient Signature Date Signed