Please choose which of the following options you would like for appointment reminders:

☐ Voice- mobile phone	(_____) _____-_____	Approved to leave voice message: Yes ☐ No ☐
☐ Text- mobile phone	(_____) _____-_____	
☐ Voice- home phone	(_____) _____-_____	Approved to leave voice message: Yes ☐ No ☐
☐ Voice- work phone	(_____) _____-_____	Approved to leave voice message: Yes ☐ No ☐
☐ Email	Email address: _____	
☐ Please opt me out of all appointment reminders.		

I acknowledge and agree that Methodist McKinney Hospital and an affiliates or vendor thereof, including collection or billing companies, may contact me by email, telephone or text message to any telephonic number or email address I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or pre-recorded message. I also agree that I will notify Methodist McKinney Hospital if I have given up ownership or control of any such telephone number.

Appointment reminders are a one-way communication and cannot be responded to. If you wish to correspond with the front office or your therapist through email, we want you to be aware that, although it is unlikely, there is a possibility that emails can be intercepted and read by other parties beside the person to whom it is addressed. Please do not include personal identifying or medical information, such as your birth date or insurance IDs.

In situations where you are unable to keep your appointment, we do have the following policy:

- If you are 15 minutes late or more and fail to notify us in advance, treatment may be rescheduled.
- We ask that all cancellations are called in at least 24 HOURS IN ADVANCE.
- Failure to show up for an appointment (“No Show”) 3 consecutive times will result in the cancellation of all remaining scheduled appointments.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- You are responsible for following up with your referring physician if you elect to stop attending your therapy appointments.

I have read the above information and understand that any communication I initiate via email is not a secure (encrypted) email system.

_____ _____/_____/_____ _____/_____/_____

Patient/Guardian Signature Patient Date of Birth Date

Methodist
McKINNEY HOSPITAL
PHYSICAL THERAPY
MANAGED BY

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: _____ / _____ / _____ /_____
Last First Initial Sr. Jr.

Nickname or Preferred Name: _____

Address: _____ / _____ /_____ /_____ /_____
Street Name and Number Apt# City State Zip Code

Phone: (_____) _____ - _____ (_____) _____ - _____ Email: _____
☐Home ☐ Mobile ☐ Work ☐Home ☐ Mobile ☐ Work

DO B: ____ / ____ / _____ Soc Sec #: _____ - _____ - _____ Gender: M ☐ F ☐ Marital Status: M ☐ D ☐ S ☐ W

☐ Employer: _____ Preferred Language: _____

(2) Emergency Contact

Name: _____ Relationship: _____

Phone: (_____) _____ - _____ ☐ Home ☐ Mobile ☐ Work

(3) Doctor Information:

Please provide Doctor who <u>referred</u> you to therapy below:

Name: _____Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
Last, First (MD, DO, DPM, Other)

Please provide your Family/Primary Care Doctor below (if different than above):

Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
Last, First (MD, DO, DPM, Other)

(4) Current Condition

Age: _____Height: _____ ft. _____ in. Weight: _____lbs
Condition to be treated:_____
Date of Injury: _____/_____/_____ Mechanism of Injury/Type of Surgery:_____
Date of Surgery (if applicable): _____/_____/_____ Describe your current symptoms: _____
_____
What is your average pain intensity on average in the last 3 days on a 0-10 scale:_____(0=none, 10=unbearable)
Did your symptoms begin because of a specific injury or gradual onset: ☐ Injury ☐ Gradual Onset
Explain: _____
How often are Symptoms Experienced: ☐ Most of the time (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)
How much have your symptoms interfered with your work or daily activities: ☐ Most of the time (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)
How are your symptoms changing: ☐ Improving ☐ Not Changing ☐ Worse
Additional Information about your current condition:_____

Methodist
McKINNEY HOSPITAL
PHYSICAL THERAPY
MANAGED BY

(5) Previous Treatment for Current Condition

Who have you seen for your injury or symptoms: ☐ No one ☐ Chiropractor ☐ Medical Doctor ☐ Physical / Occupational Therapist ☐ Other:_____
What treatment have you received for your injury or symptoms and when (approximately):_____
_____
What tests have you had related to your injury or symptoms: ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Other _____
_____

(6) Past Medical History:

Do you have any of the following:

Pacemaker/history of heart illness or surgery: ☐ No ☐ Yes |Diabetes: ☐ No ☐ Yes | High blood pressure: ☐ No ☐ Yes
Thyroid issues ☐ No ☐ Yes | Anxiety and/or Depression ☐ No ☐ Yes |History of a stroke ☐ No ☐ Yes | Arthritis ☐ No ☐ Yes
History of cancer ☐ No ☐ Yes If yes, what type_____
Are you pregnant: ☐ No ☐ Yes If yes, how many months? _____
Any falls in the past year: ☐ No ☐ Yes If yes, date of last fall:_____
List any other health problems, hospitalizations, surgeries and allergies or provide a list to your therapist:
_____

(7) Medications:

Include **All** prescriptions including anything you are taking for your current condition, over the counter drugs, herbal and nutritional supplements. **Separate List Provided: ☐ Yes ☐ No If No, please complete this section:**

Medication/Drug Name	Dosage	Times Per Day

(8) Demographic Information:

Where do you live: ☐ Private Home or Apt ☐ Assisted Living or Group Home ☐ Long-Term Care Facility
☐ Other: _____
Who do you live with: ☐ Alone ☐ Family ☐ Group Setting ☐ Personal Care Attendant
Employment status: ☐ Full-time, outside home ☐ Full-time, in home ☐ Retired ☐ Unemployed ☐ Part-time, outside home
☐ Part-time, in home ☐ Modified duty due to current injury ☐ Not working due to current injury
Does your occupation involve: ☐ Sitting at a computer for prolonged times ☐ Manual Labor ☐ Homemaker with small children
☐Other:_____
What are your hobbies? _____
_____

(9) Assistive Device Information:

Do you use: ☐ Walker/Rolling Walker/Rollator ☐ Cane ☐ Manual Wheelchair ☐ Motorized Wheelchair

If yes to any of the above, what condition necessitates the use of assistance? _____
_____

MEDICARE ONLY--PAGE 1/2

PART I

1. **Are you receiving Black Lung Benefits?**
   ☐ Yes. Date benefits began ___/___/___ ☐ No.
   BL is primary only for claims related to Black Lung.
2. **Are the services to be paid by a government research program?** ☐ No.
   ☐ Yes. **Government program will pay primary benefits for these services.**
3. **Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?**
   ☐ Yes. DVA is primary for these services.
4. **Was the illness/injury due to work related accident/condition?**
   ☐ Yes. Date of injury/illness ___/___/___ ☐ No. Go to Part II.
   Name and address of WC Plan: _____
   _____
   Policy or identification number: _____
   _____
   Name and address of your employer: _____
   _____
   Worker's Comp is the primary payer only for claims related to work related injuries or illness. Go to Part III.

PART II

1. **Was illness/injury due to a non-work related accident?**
   ☐ Yes. Date of accident ___/___/___ ☐ No. Go to Part III.
2. **What type of accident caused the illness/injury?**
   ☐ Automobile ☐ Non-automobile ☐ Other
   Name and address of no-fault or liability insurer: _____
   _____
   Insurance claim number: _____
   Liability insurer is primary only for those claims related to the accident. Go to Part III.

PART III

1. **Are you entitled to Medicare based on:**
   ☐ Age. Go to Part IV. ☐ Disability. Go to Part V. ☐ ESRD. Go to Part VI.
   Please note that a patient may have Medicare due to both Age and ESRD or Disability and ESRD but CANNOT have both Age and Disability.
   Complete All Parts associated with the above selections.

PART IV – AGE

1. **Are you currently employed?**
   ☐ Yes. Name and address of your employer: _____
   _____
   ☐ No. Date of retirement: ___/___/___ ☐ No. Never employed.
2. **Is your spouse currently employed?**
   ☐ Yes. Name and address of your employer: _____
   _____
   ☐ No. Date of retirement: ___/___/___ ☐ No. Never employed or deceased.
   If the patient answered "NO" to both questions 1 and 2, Medicare is primary unless the patient answered "Yes" in Part I or II. STOP HERE.
3. **Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?**
   ☐ Yes. Go to question 4.
   ☐ No. STOP. Medicare is the primary payer unless the patient answered "Yes" to the questions in Part I or II.
4. **Does the employer that sponsors your or your spouse's group health plan (GHP) employ 20 or more employees?**
   ☐ **Yes.** STOP. The Group Health Plan is primary. Obtain the following information:
   Name and address of the GHP: _____
   _____

MEDICARE ONLY--PAGE 2/2

Policy number: _____ Group number: _____

Name of policy holder: _____ Relation to patient: _____

☐ **No.** STOP. Medicare is the primary payer unless the patient answered "Yes" to the questions in Part I or II.

PART V- Disability

1. **Are you currently employed?**
   - ☐ Yes. Name and address of your employer: _____
   - ☐ No. Date of retirement: ___/___/___ ☐ No. Never employed.
2. **Is a family member currently employed?**
   - ☐ Yes. Name and address of your employer: _____
   - ☐ No.

If the patient answered "no" to both questions 1 and 2, STOP. Medicare is primary unless the patient answered "Yes" to questions in Part I or II.

3. **Do you have group health plan coverage based on your own or a family member's current employment?**
   - ☐ Yes. Go to question 4.
   - ☐ No. STOP. Medicare is the primary payer unless the patient answered "Yes" to the questions in Part I or II.
4. **Does the employer that sponsors your group health plan employ 100 or more employees?**
   - ☐ **Yes.** STOP. The Group Health Plan is primary. Obtain the following information:
     Name and address of the GHP: _____
     Policy number: _____ Group number: _____
     Name of policy holder: _____ Relation to patient: _____
   - ☐ **No.** STOP. Medicare is the primary payer unless the patient answered "Yes" to the questions in Part I or II.

Part VI- ESRD

1. **Do you have group health plan coverage through yourself or a family member?**
   - ☐ **Yes.** Obtain the following information:
     Name and address of the GHP: _____
     Policy number: _____ Group number: _____
     Name of policy holder: _____ Relation to patient: _____
     Name and address of your employer: _____
   - ☐ **No.** STOP. Medicare is the primary payer unless the patient answered "Yes" to the questions in Part I or II.
2. **Have you received a kidney transplant?**
   - ☐ Yes. Date of transplant: ___/___/___ ☐ No.
3. **Have you received maintenance dialysis treatments?**
   - ☐ Yes. Date dialysis began: ___/___/___ ☐ No.

   Did you participate in a self-dialysis training program?
   - ☐ Yes. Date training started: ___/___/___ ☐ No.
4. **Are you within the 30 month coordination period (1st 30 months of Medicare coverage)?**
   - ☐ Yes. Go to question 5. ☐ No. STOP. Medicare is primary.
5. **Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?**
   - ☐ Yes. Go to question 6. ☐ No. STOP. The group health plan is primary during the 30 month coordination period.
6. **Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?**
   - ☐ Yes. STOP. The group health plan is primary during the 30 month coordination period.
   - ☐ No. Initial entitlement based on age or disability. Go to question 7.
7. **Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?**
   - ☐ Yes. GHP is primary during the 30 month coordination period. ☐ No. Medicare is primary.

Methodist
McKINNEY HOSPITAL
PHYSICAL THERAPY
MANAGED BY

DISCLOSURE OF OWNERSHIP-NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Methodist McKinney Hospital has financial interest in the therapy services you will be receiving at the therapy center operating under the name of "Greater Therapy Centers"

2. You have the right to choose the provider of your therapy services. Therefore, you have the option to use a health care facility other than Greater Therapy Centers.

3. If you choose to obtain therapy services at a facility other than Greater Therapy Centers, your relationship with your physician will not be adversely affected.

The locations associated with Methodist McKinney Hospital are:

Carrollton
3733 North Josey Ln,
Suite 100
Carrollton, Texas 75007
Phone: (972) 492-9451
Fax: (844) 364-1299

McKinney
2309 Virginia Pkwy,
Suite 400
McKinney, Texas 75071
Phone: (972) 542-7360
Fax: (844) 364-1300

Plano
3501 Midway Rd,
Suite 198
Plano, Texas 75093
Phone: (972) 781-2322
Fax: (844) 364-1302

Prosper
1061 N Coleman,
Suite 140
Prosper, TX 75078
Phone: (469) 296-3411
Fax: (833) 410-3610

Allen- Edge
788 S Watters Rd,
Suite 110
Allen, Texas 75013
Phone: (469) 270-7600
Fax: (469) 270-7599

Frisco
14660 State Hwy 121
Building A, Suite 110
Frisco, Texas 75035
Phone: (214) 619-5401
Fax: (888) 965-4925

North Dallas
3423 Trinity Mills Rd,
Suite 520
Dallas, Texas 75287
Phone: (972) 662-1700
Fax: (844) 364-1301

Plano Legacy
6501 Preston Rd,
Suite 102
Plano ,Texas 75024
Phone: (469) 277-8477
Fax: (844) 894-8400

The Colony
4713 Hwy 121,
Suite 306
The Colony ,Texas 75056
Phone: (469) 362-2607
Fax: (844) 364-1303

Mesquite
1010 N Beltline Rd,
Suite 102
Mesquite, Texas 75149
Phone: (972) 288-2400
Fax: (972) 288-0222

McKinney- Edge
5305 W University Dr
McKinney, Texas 75071
Phone: (972) 529-9292
Fax: (866) 240-4179

Forney
1012 E US Highway 80
Forney, TX 75126
Phone: (972) 564-2227
Fax: (972) 564-2251

Farmersville
1022 St Hwy 78 N
Farmersville ,Texas 75442
Phone: (972)784-6533
Fax: (972) 782-8415

Frisco- Edge
11500 State Hwy 121, Suite 130
Frisco, Texas 75035
Phone: (214) 618-8075
Fax: (214) 618-8055

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Methodist McKinney Hospital and/or Greater Therapy Centers. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that Methodist McKinney Hospital has an ownership/financial interest in the care you will be receiving at Greater Therapy Centers.

_____ _____

Patient Signature | Parent or guardian Signature (if applicable)

_____ _____

Patient Printed Name | Parent or guardian Printed Name (if applicable)

_____ _____

Date | Date

Methodist
McKINNEY HOSPITAL
PHYSICAL THERAPY
MANAGED BY

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

Nursing Care: This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient needs more intensive nursing care. If the patient's condition requires the service of a special duty nurse, it is agreed that such an arrangement will be made by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

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

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

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

Please read and initial all applicable statements and check the appropriate box {DO or DO NOT}

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

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

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

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

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. I agree to pay the

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

Assignment of Insurance Benefits: I authorize direct payment to the Hospital of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

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

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

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

Patient Bill of Rights: I acknowledge that I have received the Patient Bill of Rights. INITIAL _____

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

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

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

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

Date:_____Time:_____AM/PM

Signature:_____(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship:_____

Witness (office use only):_____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative:
I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, Healthcare Service Plan Obligation provisions above.

Date:_____Time:_____AM/PM

Signature:_____ (Financially responsible party)

Witness:_____

Methodist
McKINNEY HOSPITAL

8000 West Eldorado Parkway, McKinney Texas 75070 • 972-569-2700

DISCLOSURE OF OWNERSHIP NOTICE

Dear Patient:

We are required by Federal law to notify you that this Hospital meets the Federal definition of a "physician-owned hospital" as specified in 42 C.F.R. § 482.13(b)(2). The physician who referred you to our Hospital, the Methodist McKinney Hospital, may have a financial interest in this Hospital. You are free to choose another facility in which to receive services.

Methodist McKinney Hospital Physician Investors:

Michael D. Adams, M.D.	Steve Duffy, M.D.	Chris R. Miller, M.D.
Jean Louis Benae, M.D.	Rhonda D. Hopkins, MD, PA	Andrew Minigutti, M.D.
Stephanie Berg, M.D.	William B. Humeniuk, M.D.	Steven B. Morgan, M.D.
Lee Alan Brock, M.D.	Kevin T. Joyner, M.D.	Ripul R. Panchal, D.O.
Jeffrey L. Burchard, M.D.	Justin Kane, M.D.	Manju Pandey, M.D.
Richard Burg, M.D.	Neal C. Lawrence, M.D.	H. Lynn Rodgers, Jr., M.D.
Craig A. Chambers, M.D.	David Liao, M.D.	Timothy L. Sandmann, M.D.
Jacob Chun, M.D.	Jeffrey Lue, M.D.	Brian J. Snow, M.D.
Chris Cottrell, M.D.	Daniel R. Maurer, D.O.	Ann H. Snyder, MD, PA
Jason Davis, M.D.	Doug Maxey, M.D.	Jared D. Stringer, M.D.
Sarang N. Desai, D.O.	Sacheen H. Mehta, M.D.	Jon Thompson, M.D.
Troy C. Diehl, D.O.	Wesley Merritt, M.D.	Charles Toulson, M.D.

Should you have any questions or concerns, please do not hesitate to contact me at 972-569-2700.

Sincerely,

Joe Minissale, President
Methodist McKinney Hospital

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

PATIENT'S RIGHTS:

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

provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision,

speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.

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

PATIENT RESPONSIBILITIES ARE AS FOLLOWS:

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

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

YOUR HEALTH INFORMATION RIGHTS:

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

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

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

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

PRIVACY NOTICE For your records only

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

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

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

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

CHANGES TO THIS NOTICE:

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

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

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

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT

Methodist
McKINNEY HOSPITAL

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

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

WHY WE ARE PROVIDING THIS NOTICE:

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

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

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

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

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

Methodist
McKINNEY HOSPITAL

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

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

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

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

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

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

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

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

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

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

PRIVACY NOTICE For your records only

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

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

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

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

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

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

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

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

PRIVACY NOTICE

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

OTHER USES AND DISCLOSURES:

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

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

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

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

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