TOPS Comprehensive Breast Center

Patient ID#

Name:	Date of Birth:	Age:	Exam Date:

Referring Physician:

Please circle any previous breast Imaging: Mammo / Ultrasound / MRI Location: Date:

Reason for Today's Exam? | When was your last Breast Exam by a Physician:

Do you currently have any of the following symptoms? ☐ YES ☐NO If yes, How long?

Lump/Mass ☐R ☐L Nipple Inversion ☐R ☐L

Pain/Soreness ☐R ☐L **Nipple Discharge** ☐R ☐L **What Color?**

Previous Breast surgery

Breast Biopsy ☐ R ☐ L Date _____

Lumpectomy (for CA) ☐ R ☐ L Date _____

Mastectomy ☐ R ☐ L Date _____

Breast Reconstruction ☐ R ☐ L Date _____

Breast Reduction ☐ R ☐ L Date _____

Personal history of breast cancer

☐YES ☐No Date _____

If yes, did you receive

Radiation Therapy ☐YES ☐NO

Chemotherapy ☐YES ☐NO

Hormone Therapy or Tamoxifen ☐YES ☐NO

Breast Implants ☐YES ☐NO If yes, ☐Saline ☐Silicone

Implants Removed / Replaced ☐ YES ☐NO Date Reason:

Have you had a Hysterectomy ☐YES ☐NO Date_____ Ovaries Removed ☐YES ☐NO Date _____

Taking Hormones ☐YES ☐NO How long ____ ☐Estrogen ☐Progesterone ☐Other _____

Last menstrual Period: Age at 1st menstruation: Age at 1st full term pregnancy: Age at menopause:

Weight change since last mammogram? ☐Loss ☐Gain How many lbs? Current Weight Height

Is there a family history of Breast Cancer? ☐YES, If yes, age of diagnosis. ☐NO

☐Grandmother ☐Mother ☐Daughter ☐Sister ☐Aunt ☐Cousin ☐Other

Is there a family history of Ovarian Cancer? ☐YES, If yes, age of diagnosis. ☐NO ☐ Yourself

☐Grandmother ☐Mother ☐Daughter ☐Sister ☐Aunt ☐Cousin ☐Other

Tested for BRCA1 or BRCA2? ☐YES ☐NO If yes, results? ☐ Yourself

☐Grandmother ☐Mother ☐Daughter ☐Sister ☐Aunt ☐Cousin ☐Other

Any family history of male breast cancer? ☐ YES ☐NO

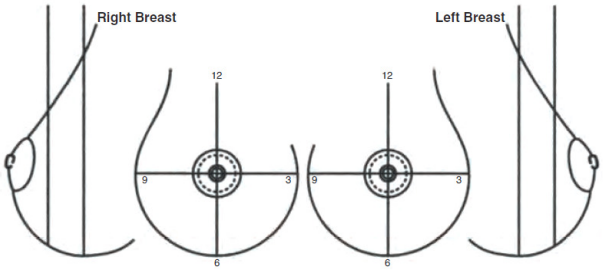
Any Ashkenazi Jewish heritage? ☐YES ☐NO

Have you received radiation to the chest between ages 10-30 for Hodgkin's Disease? ☐YES ☐NO

Have you had a Breast Cancer Risk Assessment Consultation Previously? ☐YES ☐NO

- - - - DO NOT WRITE BELOW THIS - - - - -

Using following Symbols Mark Location of: Lump (V) Scar (#) Mole (0) Tenderness (↑) RA _____%



Is Nipple Discharge Spontaneous? ☐ N/A ☐ YES ☐ NO

Technologist Signature: _____

☐ Baseline ☐ Screening ☐ Diagnostic ☐ Additional Views ☐ Short-Term F/u ☐ Tomo Location _____ PenRad _____

Verify that all information is correct and make changes as needed.

Name:	Age:	Exam Date:
Date of Birth:	Marital Status:	Patient's Race:
Address:		
Social Security:	E-mail:	
Home #:	Work #:	Cell #:
Referring Physician:		
Primary Subscriber Name:		Primary Subscriber DOB:
Relation to Subscriber:	Primary Subscriber's Employer:	
Primary Insurance Company:		
Insurance Phone#:	ID #:	Group #:
Secondary Insurance:		

I attest that the above information is correct to the best of my knowledge.

Patient Signature Date

Witness Signature Date

Patient Insurance

TOPS Comprehensive Breast Center

TOPS Comprehensive Breast Center

FACILITY ACKNOWLEDGEMENT

I understand that TOPS Comprehensive Breast Center is a department of TOPS Surgical Specialty Hospital, a physician owned facility. I also acknowledge that I have the right to choose the provider of my healthcare services and I have chosen TOPS.

Initials _____

AGREEMENT

The undersigned agrees, whether he/she signs as agent or a patient, that in consideration of the services to be rendered to the patient, he/she hereby is responsible for paying facility co-payments, deductibles, estimated facility coinsurance amounts, and any balance deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashier's check, credit card, or personal check. Self-pay procedures must be paid in full prior to services.

Initials _____

ASSIGNMENT OF INSURANCE BENEFITS* & *AUTHORIZATON* TO *RELEASE INFORMATION

In consideration of services rendered, I hereby transfer and assign to the hospital and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance.

I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to TOPS Surgical Specialty Hospital, **radiologists, pathological services.** I recognize the above physicians are independent contractors who **will generate separate bills for their respective services.** TOPS Surgical Specialty Hospital provides cost estimates and generates bills for the facility portion only. I understand I am financially responsible for the above physician's service.

TOPS Surgical Specialty Hospital files primary and secondary insurance claims for patients who are not scheduled as self-pay. I authorize the hospital and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, health or hospital plan.

Initials _____

INSURANCE

I have been informed that some insurance carriers will only pay for one screening mammogram every 365 calendar days. I am aware that any diagnostic studies may be subject to my deductible and/or not covered by my insurance policy. This includes screening mammograms that turn into diagnostic mammograms.

Initials _____

MEDICARE PAYMENTS

Patient's Certification, (Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVIII 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.

Initials _____

PATIENT BILL OF RIGHTS

I understand that I also can receive a copy of the Patient Bill of Rights and Responsibilities.

Initials _____

[Patient name] [pid] [Date of exam]

TOPS Comprehensive Breast Center

CONSENT FOR IMAGING.

I authorize the performance of imaging which the ordering physician and/or radiologist deem necessary in the course of my examination and treatment. I understand that it is my responsibility to contact my physician for results.

Initials _____

POSSIBILITY OF PREGNANCY

Radiation can be harmful to a developing fetus. If there is any possibility that you are pregnant, this exam must be discussed with your physician and possibly rescheduled.

I am NOT pregnant _____. I could possibly be pregnant _____. Last menstrual period _____

Initials _____

IMPLANTS

The presence of an implant poses a special situation for mammographic technique and interpretation since a portion of the breast tissue may be obscured by the implant. In addition, implants are subject to complications such as the possibility of rupture, leakage, or displacement during compression. Even though these complications are not common, you as a patient need to know that they can occur.

I do NOT have breast implants _____. I do have breast implants _____.

Initials _____

RISK ASSESMENT

I acknowledge that questions related to family history and risk factors may be obtained and used to calculate my individual risk of breast cancer.

Initials _____

I authorize TOPS to release or request copies of medical records and x-rays pertinent to the course of my examination.

Initials _____

PATIENT SIGNATURE ***DATE OF BIRTH*** ***TODAY'S DATE***

WITNESS ***TODAY'S DATE***

TOPS Specialty Hospital

17080 Red Oak Drive
Houston, TX 77090
(281) 539-2900

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions including refusal of treatment or not following the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, eating and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing care givers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition, or any other patient health matters.

TOPS Specialty Hospital

17080 Red Oak Drive
Houston, TX 77090
(281) 539-2900

- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeit of care at the facility.
- Promptly fulfilling his or her financial obligations to the facility.
- Identifying any patient safety concerns.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility Administrator by phone at (281) 539-2900 or by mail at:

TOPS Specialty Hospital
17080 Red Oak Drive
Houston, TX 77090

Complaints and grievances may also be filed through:
Health Department
Health Facility Compliance
1000 W. 49th St.
Austin, TX 78756-3199
(512) 834-6650

OR

State of Texas, CMS Regional Office
DHHS/CMS/DMSO, CLIA Program
1301 Young Street, Room 833
Dallas, TX 75202
(214) 767-6301

Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protections by visiting the website for the Office of the Medicare Beneficiary Ombudsman at: www.cms.hhs.gov/center/ombudsman.asp.

ADVANCE DIRECTIVE NOTIFICATION

In the State of Texas, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. TOPS Specialty Hospital respects and upholds those rights.

However, unlike in an acute care hospital setting, TOPS Specialty Hospital does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

DISCLOSURE OF OWNERSHIP

TOPS Specialty Hospital is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies of our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Your physician **does /does not** ***(circle as appropriate)*** have a financial interest in this facility.

By signing this document, I acknowledge that I have read and understand its contents:
Patient/Patient Representative Signature Date

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.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. Your "protected health information" means any written or oral information about you, including demographic data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health or condition.

Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

We may use your protected health information for the purposes of providing treatment, obtaining payment for treatment, and conduction health care operations. Your protected health information may be used or disclosed only for these purposes unless we have obtained your authorization or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. **Treatment**. We will use and disclose your protected healthcare information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:
    a. We may disclose your protected health information to a laboratory to order tests.
    b. We may disclose your protected health information to other physicians who may be treating you or consulting with us regarding your care.
    c. We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative.

2. **Payment**. We will use your protected health information to obtain payment for the services we provide to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:
    a. We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.
    b. We may disclose your protected health information to anesthesia care providers involved in your care so they can obtain payment for their services.

3. **Health Care Operations**. We may use and disclose your protected health information to facilitate our own health care operations and to provide quality care to all of our patients. Health care operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your protected health information for health care operations:
    a. We may use your protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you.
    b. We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
    c. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.
    d. We may also use or disclose your protected health information in the course of maintenance and management of our electronic health information systems.

Uses and Disclosures of Protected Health Information Permitted without Authorization or Opportunity for the Individual to Object

The federal privacy rules allow us to use or disclose your protected health information without your authorization and without you having the opportunity to object to such use or disclosure in certain circumstances, including:

1. **When Required By Law**. We will disclose your protected health information when we are required to do so by federal, state, or local law.

2. **For Public Health Reasons**. We may disclose your protected health information as permitted or required by law for the following public health reasons:
   a. For the prevention, control, or reporting of disease, injury or disability;
   b. For the reporting of vital events such as birth or death;
   c. For public health surveillance, investigations, or interventions;
   d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:
      - Collection and reporting of adverse events, product defects or problems, or biological product deviations.
      - Tracking of FDA-regulated products.
      - Product recalls, repairs, or lookback.
      - Post-marketing surveillance.
   e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
   f. Under certain limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce.

3. To Report Abuse, Neglect, or Domestic Violence. We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.

4. For Health Oversight Activities. We may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

5. For Judicial or Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.

6. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes, including:
   a. Wound or physical injury reporting, as required by law.
   b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
   c. Identification or location of a suspect, fugitive, material witness, or missing person.
   d. Under certain limited circumstances when you are the victim of a crime.
   e. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.
   f. Reporting criminal conduct that occurred on the premises of the provider.
   g. In an emergency to report a crime.

7. To Coroners, Medical Examiners, and Funeral Directors. We may disclosed protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. In some cases such disclosures may occur prior to, and in reasonable anticipation of, the individual's death.

8. For Organ or Tissue Donation. We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplant.

9. For Research Purposes. We may use or disclose your protected health information for research purposes when an institutional review board that has reviewed the research proposal and protocols to safeguard the privacy of your protected health information has approved such use or disclosure.

10. To Avert a Serious Threat to Health or Safety. We may, consistent with applicable law and standards of ethical conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public.

11. For Specialized Government Functions. We may use or disclose your protected health information, as authorized or required by law, to facilitate specified government functions related to military and veterans activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.

12. For Workers' Compensation. We may use and disclose your protected heath information, as necessary, to comply with workers' compensation laws or similar programs.

Uses and Disclosures of Protected Health Information Permitted without Authorization but with an Opportunity for the Individual to Object

We may use your protected health information to maintain a directory of patients in our facility. The information included in the directory will be limited to your name, your location in our facility, and your condition described in general terms.

We may disclose your protected health information to a friend or family member who is involved in your medical care or payment for care. In addition, if applicable, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgment that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

Uses and Disclosures of Protected Health Information which You Authorize

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. We require your written authorization in order to use or disclose your protected health information for:

- (a) marketing, except if the communication is in the form of a face-to-face communication made by us to you, or a promotional gift of nominal value that we provide to you; however, we are permitted by HIPAA to send you materials that describe health-related products or services (or payment for such products or services) that are provided by TOPS Surgical Specialty Hospital; and
- (b) any sale of your protected health information.

Authorizations are for specific uses of your protected health information, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding your protected health information:

1. **The Right to Request Restriction of Uses and Disclosures**. You have the right to request that we not use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your protected health information to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies.

   We must agree to your request to restrict disclosure of your protected health information to a health plan if:

   - the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
   - the protected health information pertains solely to a health care item or service for which you or someone else has paid out-of-pocket in full.

   Otherwise, we are not required to agree to a restriction you may request.

   We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your protected health information in violation of the agreed upon restriction, unless necessary for the provision of emergency treatment.

   We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to protected health information created or received by us after you receive the notice of termination of the restriction.

Request for restrictions must be made in writing to the Privacy Officer.

2. **The Right to Request Confidential Communications**. You have the right to request that you receive communications of protected health information from us by alternative means or at alternative locations. We must accommodate any reasonable request of this nature. We may condition the provision or accommodation by requesting information from you describing how payment will be handled, or by requesting specification of an alternative address or alternative form of contact.

Requests for confidential communications must be made in writing to the Privacy Officer.

3. **The Right to Inspect and Copy Protected Health Information**. You have the right to inspect and obtain a copy of your protected health information that is maintained in a designated record set for as long as we maintain the protected health information. The designated record set is a collection of records maintained by us, which contains medical and billing information used in the course of your care, and any other information used to make decisions about you.

By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and protected health information which is subject to a law which prohibits access to protected health information. Depending on the circumstance of your request, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You have a right to request a review of a denial of access.

If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request.

Requests for access to your protected health information must be made in writing to the Privacy Officer.

4. **The Right to Amend Protected Health Information**. You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases we may deny your request. If we deny your request you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement and if we do so we will provide a copy of our rebuttal to you.

Requests for amendment of protected health information must made in writing to the Privacy Officer, and must include a reason to support the requested amendments.

5. **The Right to Receive an Accounting of Disclosures of Protected Health Information**. You have the right to request an accounting of disclosures of your protected health information made by us. This right applies to disclosures made by us except for disclosures: to carry out treatment, payment, or health care operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; for our directory, or other notification purposes, or to persons involved in your care; or for certain other disclosures we are permitted to make without your authorization.

Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 14, 2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting request will be subject to a reasonable cost-based fee.

6. **The Right to Obtain a Paper Copy of this Notice**. Upon request, we will provide a paper copy of this notice.

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to notify you if a breach of your unsecured protected health information occurs. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer.

You will not be penalized for filing a complaint.

Contact Information

For further information about this Notice, privacy issues, or if you believe that your privacy rights have been violated, please contact:

Samuel H. Rossmann, CEO
TOPS Surgical Specialty Hospital
17080 Red Oak Dr.
Houston, TX 77090

The Administrator or CEO may be contacted by telephone at (281) 539-2900.

Effective Date: This Notice is effective April 28, 2015.

TOPS Surgical
SPECIALTY HOSPITAL

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Privacy Notice (H I PAA) for TOPS Surgical Specialty Hospital. Privacy Notice Revision Date: April 28, 2015.

_____ _____
PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE DATE

_____
PERSONAL REPRESENTATIVE'S RELATION TO PATIENT

SHADED AREA FOR USE BY TOPS Surgical Specialty Hospital Personnel Only.

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified above was provided with a copy of the TOPS Surgical Specialty Hospital's Privacy Notice (HIPAA) on this date. A good faith effort has been made to obtain a written acknowledgment of the patient's receipt of the Privacy Notice (HIPAA). However, acknowledgment has not been obtained because:

- ☐ Patient refused to sign the Privacy Notice Acknowledgment.
- ☐ Patient was unable to sign because:

  _____
- ☐ There was a medical emergency. TOPS Surgical Specialty Hospital will attempt to obtain acknowledgment as soon as practical.
- ☐ Other reason, described below:

  _____

  _____

_____ _____
EMPLOYEE SIGNATURE DATE

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Patient Label

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that TOPS Surgical Specialty Hospital and TOPS Comprehensive Breast Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, TOPS Surgical Specialty Hospital and TOPS Comprehensive Breast Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update TOPS Surgical Specialty Hospital and TOPS Comprehensive Breast Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (**If no, please provide an alternate mailing address below**.)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name:	**Telephone**
Spouse	_____	_____
Caretaker	_____	_____
Child	_____	_____
Parent	_____	_____
Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**