Tepeyac OB/GYN
Something More Than Medicine™

Patient Registration Information PLEASE PRINT – COMPLETE ALL FIELDS (Front & Back)

First Name:	M.I.	Last Name:	Social Security #:	Date of Birth:

Home Phone Number: ( )	Can we leave a msg.? (Y/N)	Cell Phone Number: ( )	Can we leave a msg.? (Y/N)	Work Phone Number: ( )	Can we leave a msg.? (Y/N)

Home Address:	City:	State:	Zip:

Email:	Marital Status: □ Married □ Single □ Divorced □ Widowed Spouse Name:

Race: ☐ Caucasian (White) ☐ Black/African American ☐ Asian ☐ Native American ☐ Asian Pacific American ☐ Pacific Islander ☐ Subcontinent Asian American
☐ American Indian or Alaskan Native ☐ Native Hawaiian ☐ Other Race ☐ More than one race ☐ Decline to answer

Ethnicity: ☐ Latino/Hispanic ☐ Other ethnicity ☐ Decline to answer

How did you hear about Tepeyac OB/GYN?

Complete ONLY if patient is a minor (under 18)

Legal Guardian First Name:	M.I.	Legal Guardian Last Name:	Legal Guardian Date of Birth:	Legal Guardian Social Security #:

Legal Guardian Home Address:	City:	State:	Zip:

Legal Guardian Home Phone Number: ( )	Legal Guardian Work Phone Number: ( )	Legal Guardian Cell Phone Number: ( )

Primary Insurance Policy Holder: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Policy Holder's Name:	Policy Holder's Phone Number: ( )		Policy Holder's Social Security #:	

Policy Holder's Address:	City:	State:	Zip:	Policy Holder's Date of Birth:

Primary Insurance Company Name:	Address:	City:	State:	Zip:

Member ID Number:	Group Number:	Co-Pay:	Effective Date:

Emergency Contacts

Primary Emergency Contact Name:	Relationship to Patient:	Phone Number: ( )

Secondary Emergency Contact Name:	Relationship to Patient:	Phone Number: ( )

Conditions of Registration

THE PRACTICE: Tepeyac Family Center LLC, doing business as Tepeyac OB/GYN, together with its physicians, advanced practice providers, employees and authorized agents, will be referred to in this document as "The Practice."

CONSENT FOR TREATMENT: I voluntarily consent to receive medical evaluation and treatment from The Practice for myself or for the minor patient for whom I am legally authorized to consent. This consent includes routine medical care and services that a treating provider determines are reasonably necessary, including examinations, diagnostic testing, laboratory services, imaging, medications, therapeutic treatment and minor procedures. I understand that medicine is not an exact science and that no guarantee has been made regarding the outcome of any examination, treatment or procedure. Certain procedures, surgeries or treatments may require a separate informed consent.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS: I authorize The Practice to submit claims and supporting information to my health insurance plan, Medicaid, Medicare or other governmental benefit program, as applicable, for services provided to me or the minor patient. To the extent permitted by law, I assign to The Practice any insurance benefits payable for services provided by The Practice and authorize payment directly to The Practice. I understand that this assignment does not release me from responsibility for any amount that I am required to pay. I authorize The Practice to communicate with my insurance plan, employer-sponsored benefit administrator or other responsible payer for purposes such as verifying eligibility, determining benefits, obtaining authorization, submitting claims, appealing payment decisions and collecting payment.

USE AND DISCLOSURE OF HEALTH INFORMATION: I understand that The Practice may use and disclose my protected health information as permitted or required by law for treatment, payment and healthcare operations. This may include sharing information with treating providers, hospitals, laboratories, imaging facilities, pharmacies, health plans, billing companies and other persons or organizations involved in my care or payment for my care. The Practice will use or disclose only the information reasonably necessary for the applicable purpose, except when the law permits or requires otherwise. I acknowledge that I have been offered or provided access to The Practice's Notice of Privacy Practices, which explains how my health information may be used and disclosed and describes my privacy rights. Disclosures that require a separate authorization under applicable law will not be covered solely by this Conditions of Registration form.

INSURANCE INFORMATION, REFERRALS AND AUTHORIZATIONS: I agree to provide complete and accurate insurance and personal information and to notify The Practice promptly of any changes. I understand that I am responsible for knowing the requirements of my insurance plan, including whether a referral, prior authorization, pre-certification or designation of a primary care provider is required. The Practice may assist with referrals or prior authorizations when required. However, verification of benefits, receipt of a referral or approval of an authorization does not guarantee that an insurance plan will pay for a service. I understand that services may be postponed when a required referral or authorization has not been received. When I choose to receive services without required insurance approval, I may be financially responsible for the resulting charges, except where prohibited by law or by The Practice's agreement with my insurance plan.

FINANCIAL AGREEMENT: I understand that I am financially responsible for charges associated with services provided to me or the minor patient, except to the extent that responsibility is limited by law or by The Practice's agreement with an insurance plan. Copayments, deductibles, coinsurance and other amounts known to be my responsibility are due at the time of service unless The Practice approves other payment arrangements. The Practice will submit insurance claims when required by an applicable payer agreement or as otherwise agreed. Insurance benefit information provided before or at the time of service is an estimate and is not a guarantee of payment. I am responsible for amounts assigned to me by my insurance plan, including:

- Copayments, deductibles and coinsurance
- Noncovered or excluded services
- Services received after coverage has terminated
- Charges resulting from inaccurate, incomplete or outdated insurance information
- Charges resulting from failure to add a patient or dependent to an insurance plan
- Services denied because required referrals, authorizations or eligibility requirements were not satisfied
- Other amounts that may lawfully be billed to me

Questions regarding how my insurance plan processed a claim should generally be directed to the insurance plan. The Practice may assist with claim questions or appeals but cannot guarantee that an insurance plan will reconsider or pay a claim.

I understand that services ordered or coordinated by The Practice may be performed or interpreted by independent organizations or healthcare professionals. These may include laboratories, hospitals, radiologists, pathologists, anesthesiologists, hospital-based providers or other specialists. I may receive separate bills from those organizations or professionals. I am responsible for confirming whether they participate with my insurance plan. If I am uninsured or choose not to use my health insurance for services, I understand that The Practice will provide a Good Faith Estimate of expected charges when required by federal law. A Good Faith Estimate is based on the information available when it is prepared and may not include unexpected services that become medically necessary. Any balance identified as my responsibility is due within 30 days after the date of the patient statement unless other payment arrangements have been approved by The Practice. Where permitted by law, interest may be assessed on balances that remain unpaid more than 90 days after the applicable final invoice. Any interest assessed by The Practice will not exceed 0.25 percent per month, equivalent to three percent annually. If a balance remains unpaid and acceptable payment arrangements have not been made, The Practice may refer the account to a collection agency or attorney after providing any notices and waiting periods required by applicable law. I may be responsible for reasonable collection costs, court costs or attorney fees only to the extent permitted by applicable law. Collection activities will be conducted in accordance with applicable federal and Virginia medical-debt requirements.

COPY OF SIGNATURE: I authorize The Practice to use a copy, electronic image or electronic version of my signature for insurance claims, payment purposes and other lawful administrative purposes. I agree that my electronic signature has the same effect as my handwritten signature.

CERTIFICATION: I certify that the personal and insurance information I have provided is accurate and complete to the best of my knowledge. I acknowledge that I have read this Conditions of Registration and Financial Agreement, or that it has been explained to me. I have had the opportunity to ask questions and agree to its terms. These terms will remain in effect for future services provided by The Practice unless they are replaced or amended in writing or revoked where revocation is permitted by law.

I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration.

Print Name	Signature	DOB	Date

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4001 Fair Ridge Drive
Suite 304
Fairfax, VA 22033
(703) 273-9440
www.tepeyacobgyn.com

MEDICAL HISTORY

Date: _____

Name: Date of Birth: Age:

MENSTRUAL HISTORY	PREGNANCY HISTORY (include term, pre-term, miscarriage & abortion)								
First day of last period: ____ /____/ _____	Name	DOB	Weeks pregnant	Type of delivery	Anesthesia	Hours of labor	Place of birth	Weight	Complications & Health
❒ Regular ❒ Irregular									
❒ Menopause ❒ Hysterectomy									
Age at onset:									
Days from start to start:									
Days of bleeding:									
# pads used daily:									
# tampons used daily:									
Non-menstrual bleeding: Y/N									
Severe menstrual pain: Y/N									

Family Planning method: ❒ Natural Family Planning ❒ Oral contraceptives ❒ IUD ❒ Condoms
❒ Female sterilization ❒ Male sterilization ❒ None ❒ N/A ❒ Other: _____

GYNECOLOGIC HISTORY

Last Pap Smear date: _____
❒ Normal ❒ Abnormal

Last Mammogram: _____
❒ Normal ❒ Abnormal

Last DEXA scan: _____
❒ Normal ❒ Abnormal

Last colonoscopy: _____
❒ Normal ❒ Abnormal

Check if you have **ever** had one of the following conditions:

- ❒ Abnormal Pap smear
- ❒ Breast Cancer
- ❒ Breast Lump
- ❒ Chlamydia
- ❒ Ectopic pregnancy
- ❒ Endometriosis
- ❒ Gonorrhea
- ❒ Herpes
- ❒ HIV
- ❒ Osteoporosis/Osteopenia
- ❒ Ovarian Cyst
- ❒ Polycystic Ovarian Syndrome
- ❒ Pelvic Inflammatory Disease
- ❒ STI/STD (other)

PERSONAL MEDICAL HISTORY (check if you have had any of the following)

- ❒ Allergies (seasonal)
- ❒ Anemia
- ❒ Anxiety
- ❒ Asthma
- ❒ Blood clot (DVT or PE)
- ❒ Cancer (specify) _____
- ❒ COPD
- ❒ Depression
- ❒ Diabetes, Type 1
- ❒ Diabetes, Type 2
- ❒ Ear disease/impairment
- ❒ Eating disorder
- ❒ GERD/Reflux
- ❒ Head injury/concussion
- ❒ Heart disease
  - ❒ Coronary artery disease
  - ❒ Heart attack
  - ❒ Heart murmur
- ❒ Hepatitis
- ❒ High cholesterol
- ❒ High blood pressure
- ❒ Kidney disease
  - ❒ Kidney infection
  - ❒ Kidney stones
  - ❒ Kidney failure
- ❒ Lyme disease
- ❒ Meningitis
- ❒ Migraines, with aura
- ❒ Migraines, without aura
- ❒ Peptic ulcer
- ❒ Pneumonia
- ❒ Rheumatic fever
- ❒ Rheumatoid arthritis
- ❒ Skin disease
- ❒ Stroke
- ❒ Thyroid disease
  - ❒ Hyperthyroidism
  - ❒ Hypothyroidism
- ❒ Trauma (physical or emotional)
- ❒ Tuberculosis
- ❒ Other:

CURRENT MEDICATIONS	ALLERGIES	PREVIOUS SURGERY & YEAR

FAMILY HISTORY

	Age & Medical conditions		Age & Medical conditions
Father		Children 1	
Mother		2	
Siblings 1		3	
2		4	
3		5	
4		6	
5		7	

Check & write **who** in your family has:

- ❒ Cancer
  - ❒ Breast
  - ❒ Endometrial
  - ❒ Ovarian
  - ❒ Colon
- ❒ Diabetes
- ❒ Heart disease
- ❒ High blood pressure
- ❒ DVT/PE
- ❒ Stroke
- ❒ Epilepsy
- ❒ Thyroid Disease
- ❒ Osteoporosis

SOCIAL HISTORY

Tobacco use? Y/N	Do you exercise regularly? Y/N
# Cigarettes daily: _____	Do you eat dairy or take calcium? Y/N
Alcohol use? Y/N	Occupation:
# beverages weekly: _____	Religion:
Sexually active: Current / Past / Never	Marital Status:

Are you currently experiencing any of the following symptoms?

CONSTITUTIONAL:
- ❒ Fatigue
- ❒ Fever
- ❒ Weight Gain
- ❒ Weight Loss

HEENT:
- ❒ Change in hearing
- ❒ Nose bleeds
- ❒ Sore throat
- ❒ Worsening vision

RESPIRATORY:
- ❒ Cough – productive or dry
- ❒ Shortness of Breath
- ❒ Wheezing

CARDIOVASCULAR:
- ❒ Chest Pain
- ❒ Leg or ankle swelling
- ❒ Palpitations

BREAST:
- ❒ Breast Lump/Mass
- ❒ Breast Pain
- ❒ Nipple Discharge

GASTROINTESTINAL:
- ❒ Constipation
- ❒ Dark/bloody stools
- ❒ Diarrhea
- ❒ Nausea/Vomiting

REPRODUCTIVE
- ❒ Painful Intercourse
- ❒ Vaginal discharge
- ❒ Vaginal itching/burning

URINARY:
- ❒ Painful Urination
- ❒ Blood in Urine
- ❒ Urinary frequency
- ❒ Loss of urine with cough/sneeze

MUSCULOSKELETAL:
- ❒ Back Pain
- ❒ Joint Pain, Stiffness, Swelling
- ❒ Weakness

NEUROLOGIC:
- ❒ Headaches (new onset)
- ❒ Memory Loss
- ❒ Numbness
- ❒ Tremors

PSYCHIATRIC:
- ❒ Anxiety
- ❒ Depression
- ❒ Insomnia
- ❒ PMS/Mood Swings

ENDOCRINE/HORMONAL:
- ❒ Excessive Thirst
- ❒ Hot flashes, night sweats
- ❒ Hot/Cold Intolerance

HEMATOLOGIC/LYMPHATIC:
- ❒ Easy Bruising
- ❒ Swollen Lymph Glands/Nodes

SKIN:
- ❒ Dry skin
- ❒ Rash
- ❒ New/changing skin lesion
- ❒ Hair loss
- ❒ Excessive body/facial hair

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Name:_____ Date of Birth:_____Today's Date: _____

Obstetric Medical & Genetic Survey

Thank you for choosing Tepeyac Family Center for your pregnancy. We look forward to walking with you through this exciting time and aim to provide you and your pre-born baby with comprehensive and excellent medical care. To do so, we must assess your risk for various medical conditions, genetic disorders, and infectious diseases. Your answers, like your entire medical record, are kept strictly confidential. Please provide as accurate and complete information as possible so we may best serve you.

OB/GYN History

Please list all previous pregnancies including term, preterm, miscarriage & abortion.

First day of last period: ___ /___/ _____ ❒ Regular ❒ Irregular	Name	DOB	Weeks pregnant	Vaginal or C-section	Anesthesia	Hours of labor	Place of birth	Weight	Complications & Health
Date of ovulation (if known): ___ /___/ _____									
Weight prior to pregnancy: _____									

Personal & Family Medical History

Please check if any of the following medical conditions apply to **you** or to a member of **your family**.

Condition	√	Comments	Condition	√	Comments
Allergies (seasonal)			Liver disease		
Anemia/blood disorder			Neurologic disorder		
Asthma/pulmonary disorder			Kidney/renal disease		
Autoimmune disorders			Rh-negative		
Abnormal Pap Smear			Thyroid disorder		
Previous Blood Transfusion			Previous trauma/accident		
Breast disorder			Reproductive abnormality		
Depression			Varicosities or blood clot		
Other psychiatric disorder			Anesthesia complications		
Diabetes (gestational, other)			Other medical condition		
Heart Disease					
High blood pressure			Tobacco use & packs/day		
Infertility			Alcohol use & drinks/day		
			Recreational or IV drug use		

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Genetic Screening

Please check if any of the following genetic conditions apply to **you**, the **father of the baby**, or **either of your families**. Provide further details in the comments section.

Condition	√	Comments	Condition	√	Comments
Your age >35 at due date			Autism		
Neural tube defect (ie. spinal bifida)			-- If Yes, were they tested for Fragile X?		
Down Syndrome			Mental Retardation		
Congenital Heart Defect			-- If Yes, were they tested for Fragile X?		
Cystic Fibrosis			Muscular Dystrophy		
Tay-Sachs			Sickle cell disease or trait		
Thalassemia			Other genetic disorder		
Canavan Syndrome			Maternal metabolic disorder (ie. PKU)		
Hemophilia or hematologic disease			3+ miscarriages, or previous stillborn		
Huntington's Chorea			Other birth defects		

Exposure to Infectious Diseases

	Yes/No	Comments
Are you or your partner HIV-positive? - Have either of you ever used IV drugs? - Have either of you had other partners in the past 5 years? - Have either of you had sexual contact with men who have sex with men?	Y / N Y / N Y / N Y / N	
Have you or your partner had genital herpes?	Y / N	
Have you ever been exposed to active tuberculosis? - Have you lived with someone with TB? - Have you lived in a country with high rates of TB? - Have you lived in a communal home, shelter or prison?	Y / N Y / N Y / N Y / N	
Since your last period, have you had a rash or viral illness?	Y / N	
Have you ever been diagnosed or treated for a sexually transmitted infection? (ie. chlamydia, gonorrhea, syphilis)	Y / N	
Have you had the chicken-pox in the past? - If not, have you received the vaccine?	Y / N Y / N	
Have you been previously diagnosed with any other infectious disease?	Y / N	
Do you own or regularly come in contact with a cat?	Y / N	

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Records Release TO Tepeyac OB/GYN

Please note that processing records for release requires 5-10 business days.

I hereby authorize the release of my medical records to:

Tepeyac OB/GYN

4001 Fair Ridge Dr., Ste. 304

Fairfax, VA 22033

Phone: 703-273-9440 Fax: 703-273-9445

□ All Records □ Other: _____

PATIENT INFORMATION:

Name:		Date of Birth:	
Address:	City:	State:	Zip Code:
Phone:	Signature of Patient or Legal Guardian:		

PROVIDER INFORMATION:

Requesting Records From:			
Address:	City:	State:	Zip Code:
Phone:	Fax:		

To avoid delay in processing your request, please complete this form with the correct information. Call your prior doctor's office and obtain their address and fax number if you do not know it.

TO THE PROVIDER: Protected Health Care Information is personal and sensitive information related to a person's healthcare. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Receipt of Notice of Privacy Practices

I have received and reviewed a copy of Tepeyac OB/GYN's Notice of Privacy Practices either online at www.tepeyacobgyn.com or by receiving a copy at the Tepeyac's office. The notice provides information about the use and disclosures of my protected health information by Tepeyac, my individual rights, and The Practice's duties with respect to my protected health information.

I understand that Tepeyac OB/GYN reserves the right to change the terms of its Notice of Privacy Practices and to make new versions effective for all protected health information it maintains, and that I can obtain Tepeyac OB/GYN's current Notice of Privacy Practices on request from Tepeyac OB/GYN and on its website.

Name:_____Signature:_____DOB:_____Date:_____
Print name of person signing if other than patient and relationship to patient: _____

HIPAA Authorization: Health & Financial Disclosure

Persons Authorized to Receive Information:

Name:	Emergency Contact? (Y/N)	Relationship to Patient:	Phone No.:	Information Authorized: (e.g. All, medical only, financial only, emergency contact only)

□ Yes, sign me up for Tepeyac's Patient Portal. Email: _____

I authorize Tepeyac OB/GYN to leave a detailed message regarding my healthcare issues or test results on my answering machine, voice mail, or text messaging attached to the following numbers specified below:

Home Phone_____Cell Phone_____Work Phone _____

I acknowledge that all of the above information will remain in effect for one year from today's date and I may revoke the(se) authorizations (except to the extent that action was already taken in reliance on the(se) signed authorizations) at any time by notifying Tepeyac OB/GYN in writing.

I acknowledge that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

I understand that I may inspect or copy any information used or disclosed under this agreement to someone who would not otherwise be entitled to use or disclose for payment, treatment, or Tepeyac operations, or as otherwise described in the Notice of Privacy Practices.

I understand that if the person or organization that received the information is not a healthcare provider, healthcare plan of Tepeyac covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

Signature:_____Date Signed: _____

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www.tepeyacobgyn.com
Patient portal: tfc.portalforpatients.com

(703) 273-9440
4001 Fair Ridge Dr. Ste. 304
Fairfax, VA 22033
info@tepeyacobgyn.com

The following 3-page Privacy Notice is for your information only and you do not need to bring it with you to your appointment.

Please complete, sign, and bring with you the **Receipt of Notice of Privacy Practices Written Acknowledgement** form found on the preceding page.

Privacy Notice

Notice of Patient Privacy Practices
For Tepeyac OB/GYN. Effective August 1, 2014

4001 Fair Ridge Drive Suite 304, Fairfax, VA 22033
Phone: (703) 273-9440 ● Fax: (703) 934-9445
www.tepeyacobgyn.com ● info@tepeyacobgyn.com

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.

Safeguarding your private health information under the Health Insurance Portability and Accessibility Act (HIPAA), as amended, the HIPAA Privacy and Security Regulations, and other federal and state laws is very important to us. We keep your health and financial information private, as required by law, and our rules. This notice explains your rights, our legal duties and privacy practices. We are required by law to give you this notice and to follow the duties and practices described in it. We will let you know promptly if a breach occurs that may compromise the privacy or security of your information. We will not use or share your information other than as described here, in which case you need to let us know of the change in writing to stop our future disclosures of your health information. Information disclosed before you have revoked your authorization will not be returned and any actions that we have already taken based on prior authorization will not be affected.

Please review this notice carefully and sign the acknowledgment form.

You may contact us to address any concerns or questions about the privacy of your health information or financial information provided to us. If you believe your privacy has been violated, you may contact us to discuss your concerns or to file a complaint. Please contact the Privacy Officer, Tepeyac OB/GYN, attn. Practice Administrator at the telephone number 703-273-9440, www.tepeyacobgyn.com, or 4001 Fair Ridge Drive, Fairfax, VA 22033. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint or voicing a privacy concern.

We may change this notice at any time. Changes will apply to the protected health information we already have about you and any protected health information about you we obtain in the future. We must tell you about any changes to our privacy notice and follow the notice in effect. We may tell you about changes by posting the revised privacy notice on our websites, posting a summary in the waiting room at our practice, and making copies available upon your request.

Your Protected Health Information

Your protected health information (sometimes abbreviated “PHI”) is information that identifies you or can be used to identify you; that either comes from you or has been created or received by a healthcare provider, a healthcare plan, your employer, or a healthcare clearinghouse; and has to do with your physical or mental health or condition, providing healthcare to you, or paying for providing healthcare to you.

How We Collect Other Information About You: Tepeyac OB/GYN (Tepeyac) and its employees’ collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do with Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in writing accepted by us.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application for care or to provide you with health or counseling services which may require communication between Tepeyac and healthcare providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to; or to obtain payment for services or products, as well as any other use permitted by law.

Your protected health information may be collected, used, and shared without your written authorization:

To treat you and care for you, including consulting with other medical professionals who are treating you and contacting you for appointment reminders;

To run Tepeyac, including improving your care through quality assessment and review, training, business planning, customer service, grievance resolution, credentialing and medical review and other general administrative activities;

To obtain payment from you, your insurance company or anyone else responsible for payment for the services we provide to you.

Under specified conditions, we may use and share some of your protected health information in other ways without your written authorization:

For public health, abuse or neglect, and health oversight, such as alerting a person who may be at risk for contracting or spreading a disease, reporting suspected abuse, neglect, or domestic violence, and preventing a serious and imminent threat to anyone's health or safety;

For law compliance, to law enforcement, as required by law, for worker's compensation claims, to health oversight agencies for activities authorized by law, and for special government functions authorized by law such as to public assistance personnel or national security personnel or for national security purposes;

For assisting a medical examiner or funeral director, when necessary to identify a deceased individual or determine cause of death;

For a response to organ and tissue donation requests;

For judicial and administrative proceedings, in response to a court or administrative order or subpoena; For certain

health research, provided other precautions have been taken to protect your information;

With family and friends if the information is directly relevant to their involvement in your healthcare or their payment for your healthcare, **unless you tell us otherwise in writing;**

In an emergency where you cannot be contacted or respond, we may disclose your protected health information to a family member, friend, or another person if sharing it is in your best interest in your doctor's professional judgment;

For any other reason where disclosure is required by law.

Fundraising Communications: We may use limited protected health information to contact you, either directly or via Divine Mercy Care, to raise funds for Tepeyac, **unless you choose to "opt-out" by telling us not to contact you for fundraising.** You can opt-out on the Fundraising Opt-Out form linked below or at any time you receive a fundraising communication. If you opt-out, you may opt back in by notifying us in writing that you would like to receive future fundraising communications.

Uses and Disclosures Requiring Us to Receive Your Prior Written Authorization: The Privacy Rule requires that we tell you that the following uses and disclosures of your PHI will be made **only with your prior written authorization** and that you may revoke that authorization: nearly all uses and disclosures of psychotherapy notes (currently not recorded by Tepeyac providers, so not applicable at this time); uses and disclosures for marketing purposes (we currently do not intend to make any); disclosures that would constitute a sale of PHI (we currently have no plans for any); and other uses or disclosures not described in this Notice. If we did not describe a use or disclosure to you in this Notice, and that use or disclosure is not otherwise required under HIPAA or applicable state law, we will first ask you to complete a written authorization. The authorization will: describe in detail the protected health information it covers; identify to whom it will be released and how it will be used; describe when it will be used or released; and state the expiration date that applies to your authorization.

Your Individual Rights Regarding Your Health Information:

You may tell us in writing that we can give your protected health information to someone else for any reason. Please use our authorization form.

If you have given medical power of attorney to someone or you have a legal guardian, that person can exercise your rights and make choices about your healthcare information. We will make sure the person has this authority and can

act for you before we take any action.

You may specify your preferred method of communication to you using means that are reasonable.

You may ask us to send you personal information to an address other than your home if sending it to your home could place you in danger.

We must give you access to your own protected health information. You have a right to see or get a copy of your protected health information and to ask that we correct it if you believe it is missing something or is incorrect. We will provide a copy or summary of your health information within 15 days of your request. We may charge a reasonable fee for medical records.

You may send us a written request to ask us not to use your protected health information for treatment, payment, or healthcare operations activities. We are not required to agree to these requests and may refuse a request that we believe would affect your care.

If you pay for a service in full out-of-pocket, you can ask us not to share information about that service for purposes of payment or our operations with your health insurer. We will agree unless a law requires us to share that information.

You may send us a written request for a list ("accounting") of certain disclosures we made of your protected health information other than disclosures about treatment, payment, and healthcare operations, and disclosures you asked us to make. We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another within twelve months.

You have a right to receive a new copy of this Notice of Privacy Practices at any time. Even if you agree to get this notice by electronic means, you still have the right to a paper copy.

MERCY Program: We offer a sliding scale financial assistance MERCY program that can provide self-pay patients with a discount of 40 to 100 percent based on household size, assets, income, and the availability of funding. Please contact our Billing Department for more information. If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors except for one hit counter on the main index page (www.tfc.portalforpatients.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture about other sites you visited simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank-you notes sent to us become the exclusive property of Tepeyac. We reserve the right to use non-identifying information about our patients (those who receive services or goods from or through us) for fundraising purposes that are directly related to our mission. Patients sending us these materials will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advance permission.

You may specifically request that NO information be used whatsoever for fundraising purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.