LOCATIONS:

The Woodlands:
920 Medical Plaza Drive
Suite 120, The Woodlands, TX 77380
Phone- 281-298-1144
Fax- 281-298-1133

Katy:
23920 Katy Freeway
Suite 150, Katy, TX 77494
Phone- 281-298-1144
Fax- 281-771-1133

Cypress:
27700 Northwest Freeway
Suite 320, Cypress, TX 77433
Phone- 281-298-1144
Fax- 281-771-1133

Sugar Land:
17520 W Grand Parkway S
Suite 120, Sugar Land, TX 77479
Phone- 281-298-1144
Fax- 281-771-1133

PATIENT INFORMATION

Patient name: _____

Address: _____ Nickname of child: _____

City: _____ State: _____ Zip: _____

Sex: (M/F) _____ Social Security #: _____ Date of Birth: _____

Race: □ American Indian or Alaska Native □ Asian □ Native Hawaiian or other Pacific Islander □ African American □ White □ Hispanic □ Other Race □ Other Pacific Islander

Father/ Guardian name: _____ Mother/Guardian name: _____

Primary Cell #: _____ Secondary Cell #: _____

Child lives with: _____ Email: _____

Referring Physician: _____ Phone: _____ Fax: _____

Primary Physician (if different than above): _____

Phone: _____ Fax: _____

Pharmacy: _____ Number: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Insured name (Policyholder): _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____ Sex: ____ Marital Status_____

Relationship to patient: _____ Policy or group #: _____

Identification #: _____ Policy type: Employer__ Group __ Non-Group____

Employer name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Work Phone#: _____

I authorize the release of any information necessary to process my insurance claims. I assign and request payment directly to THINK Neurology for Kids. I understand that I am responsible for any amount not covered by insurance.

Guardian Signature: _____ Date: _____

PEDIATRIC HISTORY

Reason for visit today:

_____
_____
_____
_____

Pregnancy complications:

_____
_____
_____
_____

Birth History:

C-Section or Vaginal
Birth Weight: _____
Full Term Y / N _____Weeks
Adopted? (Y / N) _____

Problems at Birth	Yes	No
Jaundice	___	___
Breathing problems	___	___
Seizures	___	___
Cord around neck	___	___

Other problems (explain): _____
_____

Development: At what **age** did your child:
Smile: _____ Roll over: _____ Crawled: _____
Sit alone: _____Walk alone: _____Use 1st word with meaning: _____
Use 3 word sentences: _____ Speech concerns? Yes / No _____
Were developmental skills ever lost? Explain: _____
Any concerns regarding sleep? Yes / No _____

Hospitalizations and operations:	Date
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Serious or Chronic Illness?

_____
_____
_____

Medications with dose and frequency:

_____
_____
_____

Immunizations up to date? Yes/No
Name of School: _____
Grade: _____
School problems? (Y/N) _____
Concerns regarding school performance: _____
_____
_____
504/IEP in place?_____

Child's Past Illness	Yes	No	Date
Asthma	___	___	_____
Autism	___	___	_____
Attention Deficit Disorder	___	___	_____
Seizures	___	___	_____
Migraines	___	___	_____
Syncope	___	___	_____
Congenital Heart Disease	___	___	_____
Allergies	___	___	_____
Concussion	___	___	_____
Learning Disability	___	___	_____

Allergies to Medications:

_____
_____
_____

Prior testing done: Please write approximate dates of when study was done and results if known. (When possible, please provide results of below studies or CD's with images)

MRI/CT head: _____ **EEG:** _____

Genetic testing: _____ **Other:** _____

Family History: Please list any known **diseases/disorders/neurological symptoms** in family.

Mother: _____

Father: _____

Mother's parents: _____

Father's parents: _____

Siblings: _____

Aunts/Uncles/Cousins:_____

Is the patient currently reporting any of the following symptoms? (Circle all that apply)

NEUROLOGICAL	Headaches	Seizures	Weakness	Numbness
GENERAL	Fatigue	Fever	Recent illness	Dizziness
EYES	Vision change	Blurry vision	Vision loss	Eye pain
HEAD/EARS/THROAT	Congestion	Sore throat	Ringing in ears	Hearing loss
CARDIOVASCULAR	Chest pain	Palpitations	Syncope	Exercise intolerance
RESPIRATORY	Difficulty breathing	Wheezing	Cough	Snoring
GASTROINTESTINAL	Abdominal pain	Nausea	Vomiting	Constipation
SKIN	Rash	Moles/birthmarks	Skin Lesions	Nail Changes
MUSCULOSKELETAL	Joint Pain	Joint Swelling	Back pain	Muscle pain
ENDOCRINE	Weight gain	Weight loss	Hair loss	Temperature intolerance
HEMATOLOGICAL	Easy bruising	Nose bleeds	Bleeding disorder	Anemia
PSYCHIATRIC	Depression	Sadness	Hallucinations	Anxiety

OTHER CONCERNS TODAY:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Notice of Privacy Practices as Required by Federal Law

PATIENT COPY

Purpose

The Houston Institute of Neurology for Kids ("THINK") and its staff follow the privacy practices described in this Notice. This Notice, in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), describes the general ways your protected health information ("PHI") may be used and disclosed in order for THINK to provide you with medical treatment and to collect payment for the services rendered to you by THINK. PHI, as defined by HIPAA, means your personal health information which is found in your medical and billing records and which relates to your past, present, or future physical or mental health conditions or the provision of payment for services related to those health conditions. During the course of treatment, payment and health care operations activities, this may include information created or received by health care providers, insurance companies, and/or your insured's employer.

Your Health Information Rights

You have the following rights regarding your PHI. To exercise any of the following rights, you must submit a written request

• Inspect and copy. You may inspect and/or receive a copy of your PHI maintained by THINK. THINK may charge you a reasonable fee for printing your information, in accordance with Texas Law.

• Request amendment. If you believe your PHI maintained by THINK is incorrect or incomplete, you may request an amendment to your information. THINK is not required to agree to your request.

• Request restriction. You may request limitations on how THINK uses and/or discloses your PHI. THINK is not required to agree to your request. If THINK agrees to your request, THINK will comply with your request unless the use or disclosure is necessary in order to provide you with emergency treatment or is otherwise required by law.

• Receive confidential communications. You may request communications from THINK regarding your PHI be provided to you in a certain way or at a certain location. For example, you may prefer to receive mail regarding your PHI at an address other than your usual mailing address. You must specify how or where you wish to be contacted; otherwise any available phone or address provided by you will be utilized.

• Accounting of disclosures. You may request a list of disclosures made by THINK of your PHI to persons or entities other than for the purposes of treatment, payment or health care operations, or pursuant to your specific authorization

THINK Responsibilities

THINK is required by law to ensure your PHI is kept private in accordance with federal and state law and provide you with notice of THINK's legal duties and privacy practices with respect to your PHI. THINK is required to abide by the terms of this notice as long as it is in effect. If THINK revises this Notice, THINK will follow the terms of the revised Notice as long as it is in effect.

Use and Disclosure of Your Protected Health Information

The following is a list of ways THINK may use and disclose your PHI. Not every possible use or disclosure in any given section is listed. However, all of the ways THINK is permitted to use and disclose your PHI will fall within one of the bold-faced print sections below.

• **Treatment**. THINK may use your PHI to provide you with medical treatment or services. THINK may disclose your PHI to doctors, nurses, technicians, medical students or other members of your health care team to keep them informed about your care status or condition as necessary.

• **Payment**. THINK may use and disclose your PHI to obtain payment from your insurance company or a third party. For example, THINK may need to provide your health plan with information about treatment you received for an ear infection so that your health plan will pay us or reimburse you for the treatment. Also, THINK may disclose your PHI to your other health care providers to assist those providers in obtaining payment from your insurance company or a third party.

• **Health Care Operations**. THINK may use and disclose your PHI for routine health care operations

• **Appointments and Alternatives**. THINK may use and disclose your PHI to contact you to provide appointment reminders, prescription refill reminders, and other communications regarding your case management or health care coordination

• **Business Associates**. THINK may disclose your PHI to THINK business associates in order to carry out treatment, payment, or health care operations.

• **Health Oversight Activities**. THINK may disclose your PHI to a health oversight agency or entity for activities authorized by law, such as audits, investigations, inspections, and licensure.

• **Public Health Activities**. As required by law, THINK may disclose your PHI for public health activities.

You may revoke any prior authorization in writing. A written revocation will not apply to any previous use or disclosure of PHI made in good faith under a prior authorization.

Changes to This Notice

THINK reserves the right to change this Notice and to make the revised Notice effective for PHI THINK already has about you as well as any information THINK receives in the future. A copy of the current Notice or a summary of the current Notice will be available at our office and on our website, www.ThinkKids.com.

CONSENT TO TREAT

Notice of Privacy Practices Acknowledgement

_____
(Please initial)

I acknowledge that The Houston Institute of Neurology for Kids provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

General Consent to Treat

_____
(Please initial)

I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that The Houston Institute of Neurology for Kids and its designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

_____
(Please initial)

In agreement with federal and state law, I agree to allow The Houston Institute of Neurology for Kids to deliver the necessary care to this child in order to provide continuity of care and treatment. The Houston Institute of Neurology for Kids and/or the patient's provider may obtain from any source and examine use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

Electronic Prescriptions (E-Prescribing)

_____
(Please initial)

I voluntarily authorize The Houston Institute of Neurology for Kids to allow E-Prescribing for the patients mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.

_____
(Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Name of Patient _____
Patient's Date of Birth _____
Guardian Name _____
Relationship of Patient's Guardian _____
Guardian Signature _____
Date_____

THINK OFFICE POLICIES AND PROCEDURES

In an effort to answer your questions and improve our efficiency, we have compiled the following office policy.

OFFICE HOURS: 7:00am-4:00pm (Monday-Thursday) and 7:00am-3:00pm Friday. When calling for an appointment, please tell the appointment secretary the nature of the problem. More acute/severe cases are given priority. We make every effort to keep on schedule. Delays can occur. **Please help us keep on schedule by arriving for your appointment 15 minutes prior to your appointment time.** If you arrive more than 15 minutes late for your appointment we may have to reschedule the visit. If it is necessary for you to cancel your appointment, you must give us twenty-four hours' notice. If you do not cancel your new patient appointment at least 24 hours in advance, we may not permit you to reschedule. In addition, there may be a charge for follow up appointments canceled less than 24 hours in advance.

THE ROLE OF THE REFERRING PHYSICIAN: Since this is a practice in consultative Pediatric Neurology, it is mandatory that each child have a primary care physician, be it a general pediatrician or family doctor. Your child's primary care physician will be kept informed of your child's progress and current neurological status. Your primary care physician is the doctor you should contact for your child's routine care.

AFTER OFFICE HOURS: The phone is answered after hours 7 days a week via voice mail system. Instructions are given to leave a message which will be returned the next business day. If it is an emergency, please call 911 or go to your local ER. If you subscribe to "Caller ID" and "Anonymous Call Rejection", please be advised that most phones utilized by our doctor have caller ID blocking and will reflect "anonymous" or "private" when your phone calls are returned. Be aware that this could cause a problem if the doctor needs to reach you with information regarding your child. **Prescription refills are not handled after hours.**

MEDICATION: Requests for medication refills should be called in during regular office hours. Please do not request refills for medications after hours. Keep track of your supply of medication and request refills before running out. Forty-eight hours (two working days) notice is required to refill regulated prescriptions. **There is a $10.00 charge to process same day regulated prescriptions** and must be paid when picked up or mailed, this is not covered by your insurance company and will not be filed. Note the date on the prescription; you have 21 days to have it filled. There is a $10.00 fee for replacing duplicate or lost prescriptions. Expired prescriptions not filled by the pharmacy must be returned to our office. Follow up appointments are very important. **Refills will not be authorized if follow up appointments are not kept.** If you do not keep your appointment with our doctor, you will need to follow up with your PCP to get your refill.

MEDICAL RECORDS: Letters and narrative reports are routinely sent to the primary care physician within 24 hours of your visit. We require written consent from a parent or a guardian prior to sending medical records to anyone other than your primary care physician. NO INFORMATION REGARDING PATIENTS WILL BE RELEASED TO ANYONE WITHOUT WRITTEN AUTHORIZATION FROM THE PARENT OR GUARDIAN. If you want a copy of your child's records sent to another physician or for any other reason, you must provide us with written authorization including the name and address where you wish records to be sent. We request ten working days to process medical records requests. In addition, there may be a fee charged for copying the records of 20 pages or more.

Guardian Name: _____ Relationship to Patient: _____ Date: _____

Guardian Signature: _____

Patient(s) Name: _____ Patient Date of Birth: _____

THINK FINANCIAL POLICY

Updated 5/2020

We at The Houston Institute of Neurology for Kids (THINK) are committed to providing quality care and we are pleased to discuss our fees for professional services with you at any time requested. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. If you are enrolled in a plan we have a contract with, you are only required to pay the co-payment/deductible/co insurance at the time of your visit provided you bring your referral, if needed, with you **before or on the day of your visit**. We require that arrangements for payment of your estimated share be made before being seen by the physician. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed to us, you recognize an obligation to promptly remit same payment to The Houston Institute of Neurology for Kids. This does not apply for those patients that are on an HMO plan or considered Worker's Compensation.

UNACCOMPANIED MINORS: Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE: THINK does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. Payment is the responsibility of the parent who brings the child in the office for treatment. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parties and the courts and we cannot be placed in the middle. If the divorced parents cannot agree on treatment for their child we may not be able to continue to treat them.

REGARDING INSURANCE: Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

REGARDING HSA/HSR: We **DO NOT** collect from HSA/HSR accounts. If it is paid through your insurance we will immediately refund you once we receive payment.

REGARDING BEING LATE: Arrival **greater than 15 minutes** after appointment time will result in a $25 late fee and the option to reschedule **or** be seen in the next available time slot if one is available. If no time slot is available you will need to reschedule.

APPOINTMENT CANCELLATION / NO-SHOWS: Failure **to** provide **24 hours' notice** when canceling said appointments**, or not showing up for your appointment** will result in a **$50** fee being assessed, as these appointment times could have been given to another patient(s) in need. Please be advised that reminder phone calls and emails are made as a courtesy to you and do not relieve you of the responsibility for remembering your child's appointment.

We **DO NOT ACCEPT SECONDARY INSURANCE**, third party insurance, social security or auto accident claims. We only accept and file with your **primary insurance.**

If you require a **referral number** from your insurance carrier, please understand that this is your responsibility as the insured to obtain this from your PCP and not our office.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.
- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to THINK. Any changes in this authorization must be received in writing within 30 days of the effective date.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Billing is automated and accounts over 90 days past due are automatically turned over to an agency for collection. There is a $25.00 fee if we have to turn your account over to an agency for collection. We do accept MasterCard, VISA, and Discover for your convenience. Medicaid assignment is accepted if it is the primary insurance. These fees are not covered by your insurance plan.

Guardian Name: _____ Relationship to Patient: _____ Date: _____

Guardian Signature: _____ Guardian Date of Birth: _____

Patient(s) Name: _____ Patient Date of Birth: _____

Acknowledgment

_____ **(Initials)** You are responsible for any charges at the time of service. We **DO NOT** collect from HSA/HSR accounts. If it is paid through your insurance we will refund you once we receive payment.

_____ **(Initials)** Late/No Show Policy: We strive to follow a strict schedule to avoid wait times. Due to this, if you are more than **15 minutes** late for any appointment, you will be charged a $25 late fee and have the option to reschedule **or** be seen in the next available time slot if one is available. If no time slot is available you will need to reschedule.

_____ **(Initials)** Failure to provide 24 hours' notice when canceling said appointments, or not showing up for your appointment will result in a **$50** fee being assessed. Please be advised that reminder phone calls are made as a courtesy to you and do not relieve you of the responsibility for remembering your child's appointment.

_____ **(Initials)** We **DO NOT ACCEPT SECONDARY INSURANCE**, third party insurance, social security or auto accident claims. This is in effect for all patients, regardless of insurance carrier, and everyone is treated equally.

_____ **(Initials)** Every insurance plan is contracted differently and we are not always aware of the various levels of coverage. Therefore we are not able to anticipate the final out of pocket costs at the time of your visit, but will do our best on the estimation.

_____ **(Initials)** All children must be closely supervised at all times. We want to maintain a clean, well-kept office. **Please do not allow children to climb or mark on walls, chairs, tables, books, etc.** Any damage caused by your child(ren) will be billed to you for the replacement costs and/or you may be asked to find another provider for your child(ren).

_____ **(Initials)** **NO FOOD OR DRINKS** are allowed into the clinic to prevent spills and to avoid exposure for children with food allergies (baby formula excluded). Any damages secondary to food or drinks will be billed to family.

_____ **(Initials)** There is a $10.00 charge for all triplicate (controlled drug) prescriptions for same day pickup.
Our office requires a 48-hour notice when requesting any medication refill. NO refills are approved after hours. You are required to call during office hours to script refill requests. Refills after missed follow-up visits will not be approved.

_____ **(Initials)** I acknowledge that I have been presented with and have read and understood the Policies & Procedures provided to me by The Houston Institute of Neurology for Kids. I agree to abide by the policies of The Houston Institute of Neurology for Kids.

_____ **(Initials)** Insurance Carriers Requiring Referral Numbers (Medicaid, HMO, POS, EPO): If you're insurance carrier requires you to have an insurance referral prior to you're seeing a specialist, our office must be in receipt of the insurance referral number before your arrival. If we do not have it upon sign-in, your appointment will be rescheduled to a later date and time. In the case that we are unaware that you're insurance requires a referral number and they do not cover the visit you will be responsible for any charges accrued.

Guardian Name: _____ Date:_____

Guardian Signature: _____

CONSENT FORM FOR TAKING YOUR CHILDS PHOTO TO BE PLACED IN THE PATIENT CHART FOR THE HOUSTON INSTITUTE OF NEUROLOGY FOR KIDS

As the parent/guardian of _____, I give my permission for my child's photo to be used in the patient chart.

This picture will only be used for internal records. I can request that my child's picture be removed from the chart at any time.

Signed Permission will be kept as part of your child's medical record.

_____ _____

Parent/Guardian Signature *Date*

THINK
NEUROLOGY FOR KIDS

Authorization for Non-Parent Consent for Care

Name of Patient _____

Patient's Date of Birth _____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____	_____
Name of Person	Relationship to Child
_____	_____
Name of Person	Relationship to Child
_____	_____
Name of Person	Relationship to Child
_____	_____
Name of Person	Relationship to Child

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a health care provider licensed in the state to Texas. The consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Guardian Signature (if 18 years or older) _____

Relationship to Patient _____

Date _____

Witness _____

Informed Consent for Telemedicine Services

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

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with pediatric neurology and development.

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a) Details of your medical history, examinations, x-rays and labs will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b) A physical examination of you may take place.
   c) A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d) Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Oklahoma state law apply to information disclosed during this telemedicine consultation.

5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.

6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Oklahoma, and that Oklahoma law shall apply to all disputes.

7. PAYMENT OF SERVICES: You agree that THINK reserves the right to bill a telemedicine visit to your respective insurance company. As well, you are responsible for any patient portion of the telemedicine consult, before your telemedicine consult will be scheduled. In the event your insurance company deems a service to be "non-covered" you understand that you are personally responsible for payment.

8. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultation for the procedure(s) described above.

Signature: _____ Date: _____

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to Share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be disclosed; Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PATICIPATE IN THE MHiE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this consent at any time by completing the MHiE notice of revocation. The MhiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange