Registration Form

PATIENT INFORMATION

Patient Last Name _____ First _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____Email Address_____

DOB _____Marital Status _____

Employer Name _____ Job Title _____

Employer Address _____ Work Phone_____

Employer City _____ State _____ Zip _____

Emergency Contact

Name _____ Phone _____

Relationship to you _____

Address _____

POLICY HOLDER INFORMATION

Name _____ DOB _____

Address _____

Relationship _____

Employer _____ Phone _____

Employer Address _____

On the job injury? Yes / No Date _____ Motor Vehicle Accident? Yes / No Date _____

Employer Name _____ Job Title _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to UltraSound Associates USA, LLC. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider via mail, email, fax, or website. I authorize UltraSound Associates USA, LLC to release to my insurance company any medical information which may be necessary to process my insurance claims. I understand that in the event my insurance company denies the claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of UltraSound Associates USA, LLC Privacy Practices. Initials _____

Print Name _____

Signed_____ Date_____

ULTRASOUND HISTORY & SCREENING FORM

Date _____ Patient Name _____ Sex M / F

Age _____ DOB _____ Weight _____ Height _____

Female Patients Only

First day of Last Menstrual Cycle _____ Are you pregnant? YES or ___ NO or N/A

How many times have you been pregnant? _____ How many children have you delivered? _____

Have you had previous imaging related to this problem? Yes _____ No _____

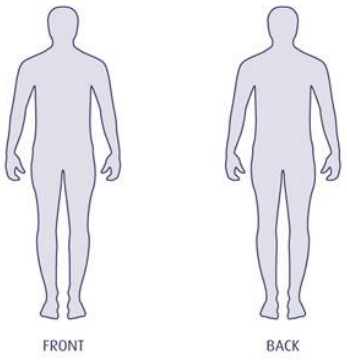
If Yes, where was the exam performed _____

List any other medical problems _____

List all previous surgeries _____

List all allergies _____

Draw on the figure below where the pain or symptoms are located:



Do you have pain? YES or NO or N/A

How long have you had this pain? _____

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant or breast feeding currently.

_____ _____

Patient / Parent / Legal Guardian Signature Date

Technologist Notes _____

_____

_____

_____

Technologist Signature Date

UltraSound Associates USA, LLC
3535 Briarpark Dr, Suite 101
Houston, TX 77042
713-434-6954 Office
713-814-9074 Fax

Informed Consent for Ultrasound / Sonogram

Patient Name: _____ DOB: _____

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound waves and a computer to produce images of internal body parts.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes that a sonogram to be the best diagnostic test for you after evaluating your symptoms and medical condition at this time.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____Date: _____
Patient/ Parent/ Legal Guardian Signature

_____ Date: _____
Technologist Signature

Additional Technologist Notes

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directs health care providers, payers, and other health care entities to develop policies and procedures to ensure the security, integrity, privacy and authenticity of health information, and to safeguard access to and disclosure of health information. The federal government has privacy rules which require that we provide you with information on how we might use or disclose your identifiable health information. We are required by the federal government to give you our **Notice of Privacy Practices**.

OUR COMMITMENT TO YOUR PRIVACY As a health care provider, we use your confidential health information and create records regarding that health information in order to provide you with quality care and to comply with certain legal requirements. We understand that this health information is personal, and we are dedicated to maintaining your privacy rights under Federal and State law. This Notice applies to records of your care created or maintained by UltraSound Associates USA, LLC that are subject to HIPAA. We are required by law to: (1) make sure we have reasonable processes in place to keep your health information private; (2) give you this Notice of our legal duties and privacy practices with respect to your health information; and (3) follow the terms of the Notice that are currently in effect. This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

Medical Staff Members – UltraSound Associates USA, LLC and other health care providers who are members of UltraSound Associates USA, LLC's medical staff are considered to be an organized health care arrangement under federal law for the specific purpose of sharing patient information. As such, UltraSound Associates USA, LLC and its medical staff will share health information about patients necessary to carry out treatment, payment and health care operations. Although all independent medical staff members who provide care at UltraSound Associates USA, LLC follow the privacy practices described in this Notice, they exercise their own independent medical judgment in caring for patients and they are solely responsible for their own compliance with the privacy laws. UltraSound Associates USA, LLC and independent medical staff members remain completely separate and independent entities that are legally responsible for their own actions.

Health Information Exchanges (HIE) – Health information exchanges allow health care providers, including UltraSound Associates USA, LLC, to share and receive information about patients, which assists in the coordination of patient care. UltraSound Associates USA, LLC participates in an HIE that may make your health information available to other providers, health plans, and health care clearinghouses for treatment or payment purposes. Your health information may be included in the HIE. We may also make your health information available to other health exchange services that request your information for coordination of your treatment and/or payment for services rendered to you. Participation in the HIE is voluntary, and you have the right to opt out. During UltraSound Associates USA, LLC's normal business hours, patients or their personal representatives may call our office at 713-434-6954 with a verbal request to opt out of the HIE.

Appointment Reminders– We may use or disclose health information to remind you that you have an appointment. If you have an answering machine, we may leave a message. We may also send appointment reminders via text message or email.

A. Payment, Health Care Operation

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operation
We are permitted to use or disclose your medical information for the purposes of health care operations which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

B. Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death, or injury by a public health authority). We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceeding and Law Enforcement
We may disclose your medical information during judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal processes, such as a warrant or subpoena.
- The information pertains to a victim of crime, and you are incapacitated.
- The information pertains to a person who has died under circumstances that may be related to criminal conduct.
- The information is about a victim of crime, and we are unable to obtain the person’s agreement.
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation
We may disclose your medical information as required by worker's compensation law.

Military, National Security and Intelligence Activities Protection of the President
We may disclose your medical information for specialized governmental functions such as separation of discharge from military services, requests as necessary by appropriate military command offers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law
The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. WE will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have ego agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information has been compiled in anticipation of litigation

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. IF we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You May request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physician(s) in the practice
- The information is not part of the designate record set
- The information is not available for inspection because of an appropriate denial
- The information is accurate and complete

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the correct information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by your or representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits
We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

Texas Department of Health
Health Facility Licensing and Compliance Division
1100 West 49th Street
Austin, TX 78756
Telephone: 888-973-0022

Medicare Ombudsman contact: 1-800-MEDICARE; www.sms.hhs.gove/center/ombudsman.asp
Complaints may be registered with the department by phone or in writing. A complainant may provide his/her name, address, and phone number to the department. Anonymous complaints may be registered. All complaints are confidential. This facility may use or disclose information about you to bill or receive payment for services and/or supplies provided to you to which you consent to by your signature below.

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation by calling 1-800-201-9553 or in writing to the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
PO BOX 2018 MC-263
Austin, TX 78768-2018

F. Our Promise to You
We are required by law and regulation to protect the privacy of your medical information to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact: **OFFICE MANAGER.**

UltraSound Associates USA
3535 Briarpark Dr, Ste 101
Houston, TX 77042
713-424-6954 Office
713-814-9074 Fax

This notice is effective September 1, 2023
NOTICE: The office of the General Counsel of the Texas Medical Association provides this information with the express understanding that (1) no attorney-client relationship exists, (2) neither TMA nor its attorney are engaged in providing legal advice and (3) that the information is of general character. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.

Acknowledgement of Review of Notice of Privacy Practices
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Patient Name Printed

_____
Patient Date of Birth