

• CONSTITUTIONAL SYMPTOMS

Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

• EYES

Eye disease or injury No Yes
 Wear glasses / contact lens No Yes
 Blurred or double vision No Yes
 Glaucoma No Yes

• EARS / NOSE / MOUTH / THROAT

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problem or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

• CARDIOVASCULAR

Heart trouble No Yes
 Chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath with walking or lying flat ... No Yes
 Swelling of feet, ankles or hands No Yes

• RESPIRATOR

Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Asthma or wheezing No Yes

• GASTROINTESTINAL

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements or constipation ... No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal Pain or heartburn No Yes
 Peptic ulcer (stomach or No Yes

• GENITOURINARY

Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male - testicle pain No Yes
 Female - pain with periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female - # pregnancies _____ # miscarriages No Yes
 Female - date of last pap smear _____ No Yes

• MUSCULOSKELETAL

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

• INTEGUMENTARY (skin, breast)

Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

• NEUROLOGICAL

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsion or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Stroke No Yes
 Head injury No Yes

• PSYCHIATRIC

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

• ENDOCRINE

Glandular or hormone problem No Yes
 Thyroid disease No Yes
 Diabetes No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

• HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Authorization For Release Of Medical Records

Patient Name _____ Date of Birth _____
Last First Middle

Street Address _____ City _____ State _____ Zip _____

Records Release Form:

Name _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Record Release To:

Name _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Type or extent of information to be released or received (check all applicable boxes):

- | | |
|---|---|
| <input type="checkbox"/> Medical history, examination reports | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Tests or treatments | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Other _____ |

Purpose Or Need For Release: _____

This authorization will remain in effect for ninety (90) days per Texas State Law. This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

X _____
Signature of Patient

Date

(If signed by someone other than patient, state relationship to patient.)

Patient is: Minor Incompetent Deceased

Legal Authority: Patient or legal guardian Next of kin of deceased

Dear Medicare Patient:

In order to properly file your charges with Medicare, we have been instructed to ask you the following questions. Please answer all of the questions in full. If your status changes at any time in the future, you must let us know at the time of your next date of service so that we can update your account.

(Please check the appropriate answer, or fill in the blank[s])

Name: _____ **Medicare Number:** _____

Age: _____ **Date of Birth:** _____ **Sex:** Male Female

Basis for Medicare eligibility: Age Disability End Stage Renal Disease

• Are you or your spouse currently working full or Part-time? Yes No

• If NO, please provide the following:

Retirement Date of Patient _____

Retirement Date of Spouse _____

• If you and/or your spouse work(s), how many employees does your employer or your spouse's employer have? Less than 20 More than 20

• Are you covered under an employer Group Health Plan based on the current employment of you or your spouse? Yes No

• If YES, please provide the following:

• Name of insured and relationship to patient (self, spouse)

_____;

• Name and Address of employer

_____;

• Name and Address of Insurance Company

_____;

• Group Identification Number

_____;

• Policy Identification Number

_____.

+

+

- Are you entitled to Black Lung Medical Benefits? Yes No
- Was this service for treatment of a work-related injury or illness? Yes No
 - If YES, provide the name and address of the Workers' Compensation Agency, the Worker's Compensation Carrier and your employer.

- Was this service for the treatment of an illness or injury which resulted from an automobile or other accident? Yes No
 - If YES, provide the name, address, and policy number of the automobile or non-automobile liability or no-fault insurer:

Policy Number: _____

- Do you have a veterans Administration fee service card? Yes No
- Are the services to be paid by a government program such as a research grant? Yes No

Patient's Signature _____

Date _____

ONETIME MEDICARE FILING AUTHORIZATION

I authorize any holder of medical information concerning me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature _____ Date _____

(if unable to sign) _____
Signature of person signing for patient and relationship

Reason for inability of patient to sign

+

+

+

+

+

NURSING ASSESSMENT

Please complete this short questionnaire so that we can evaluate your current condition and speed your visit with the doctor. Thank you for your cooperation.

Name _____
(first) (middle) (last)

REFERRING DOCTOR _____

REASON FOR SEEING DOCTOR TODAY _____

Have you had recent tests (X-rays, blood tests, etc.) for this particular condition?
 Yes _____ / No _____

Name of Test

Date of Test

Place of Test _____

Do you have a written report with you? Yes _____ / No _____

Do you have x-ray films with you? _ Yes _____ / No _____

SWAT SURGICAL ASSOCIATES, L.L.P.

Consent For Use And Disclosure of Protected Health Information For Treatment, Payment, Or Healthcare Operations

I understand that as part of my healthcare, the Physician originates and maintains medical records describing my health history, symptoms, examinations and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. The Physician also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between my Physician and healthcare professionals that act under the direction of my Physician and participating in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment and the qualifications of healthcare practitioners.

I have been provided with a copy of the Physician's *Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the *Notice* may change. If they do, I may obtain a revised copy from the privacy officer by calling 799-7928.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, the Physician may refuse to treat me. I wish to restrict the use of disclosure of my health information as follows:

I understand that my confidential information may be released to the following individuals:

Signature of Patient or Representative

Date

Patient Name

Patient Identification Number (SSN)

Name of Representative (if applicable)

Relationship

SWAT Surgical Associates, L.L.P.

Patient Financial Responsibility

We are committed to providing you with the best possible surgical and medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, and American Express.
2. Our office participates with a variety of insurance plans. It is your responsibility to:
 - Bring your insurance card at every visit
 - Be prepared to pay your co-payment and/or co-insurance at each visit. Payment can be made by cash, check, or credit card.
 - For medical care not covered, deemed medically unnecessary, or deemed cosmetic by your insurance company, payment in full is due at the time of the visit.
3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service. A deposit will be required for all surgeries.
4. If the total patient balance due cannot be paid in full, arrangements must be made prior to services being rendered. Failure to make arrangements with SWAT Surgical Associates, L.L.P. will result in the immediate collection turnover or payment in full.
5. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for all services rendered.
6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
7. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department.
8. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, SWAT Surgical Associates, L.L.P. may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be asked prior to services provided.

Patient Signature _____

Date: _____

SWAT Surgical Associates L.L.P.

***Notice of
Privacy Practices***
Effective 4/14/03

**SWAT Surgical Associates, L.L.P. (SWAT)
NOTICE OF PRIVACY PRACTICES**

This notice describes how your medical information may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

WHO DOES THIS NOTICE APPLY TO?

SWAT provides health care to our patients and clients in partnership with other professionals and organizations. The following people will follow these privacy practices:

- Any SWAT health care professional authorized to enter information into your chart.
- All SWAT departments and units.
- Any member of a volunteer group that is authorized by SWAT to help you.
- All SWAT employees, staff and other personnel.
- Any business associate with whom SWAT shares health information.

OUR RESPONSIBILITY TO YOU REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you is personal. We are committed to protecting your private medical information. In an effort to provide the highest quality medical care and to comply with certain legal requirements, we will and are required to:

- Keep your medical information private.
- Provide you with a copy of this notice.
- Follow the terms of this notice.
- Notify you if we are unable to agree to a restriction that you have requested.
- Accommodate your reasonable requests to communicate health information by alternative means or at alternative locations.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose your medical information for **TPO**:

1. For you **treatment**: such as sending medical information about you to a specialist as part of a referral,
2. To obtain **payment** for you treatment: such as sending billing information to your insurance company or Medicare,
3. To support our health care **operations**: such as comparing patient data to improved treatment methods.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT OR OPERATIONS (TPO).

Treatment: Information received by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine your course of treatment. We will also provide your physician or a subsequent healthcare provider with copies of reports to assist him or her in treating you.

Payment: A bill may be sent to you or an insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used in your treatment.

Operations: SWAT employees, staff, and physicians may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

HOW WILL MY INFORMATION BE USED?

- We may contact you for **appointment reminders**, or to tell about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you.
- We may contact you to solicit support for certain **fundraising activities**. (You will have an opportunity to refuse or opt-out of receiving this information upon the first contact by us.)
- We **will release** medical information about you to a family member, friend, or any other person that is **involved** in your medical care. We **will not release** medical information about to a family member, friend, or any person that is **not involved** in your medical care. We may give information to those that you identify as responsible for payment of your care.

WE MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU WITHOUT YOUR PRIOR AUTHORIZATION FOR SEVERAL OTHER REASONS.

Subject to certain requirements, we may give out medical information about you without prior authorization for the following purposes:

- **Research.** We may use and disclose medical information about you for research purposes. All research projects are subject to a special approval process through the appropriate SWAT committee.
- **Law.** We may disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

- **Public health.** We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc. as required by law.
- **Business associates.** There are some services provided in our organization through contracts with business associates (ie. we may disclose medical information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the health care services we provide). To protect your health information we require the business associate to appropriately safeguard your information.
- **Notification.** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
- **Funeral directors.** We may disclose health information to funeral directors consistent with applicable law for them to carry out their duties.
- **Organ donation.** Consistent with applicable law, we may disclose health information to organ procurement organizations for the purpose of tissue donation and transplant.
- **Food and Drug Administration (FDA).** We may disclose to the FDA health information relative to adverse events.
- **Workers' Compensation.** We may disclose health information necessary to comply with laws relating to Workers' Compensation or other similar programs established by law.
- **Correctional institution.** Should you be an inmate of a correctional institution, we disclose to the institution or its agents health information necessary for our health and the health and safety of other individuals.
- **State Requirements.** Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

OTHER USES OF MEDICAL INFORMATION

In any other situation not covered by this notice, we will ask you for your written authorization before using or disclosing your medical information. If you choose to authorize us to use or disclose your health information, you can later revoke that authorization by notifying us in writing of your decision, except to the extent that action has already been taken by us upon an authorization given to us.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Although your health record is the property of SWAT the entity that created it, you have the right to:

- Request a restriction, in writing*, on certain uses or disclosures of your medical information for treatment, payment or health care operations, with the exception of emergency situations.
- We will inform you of our decision on your request, **but we are not legally required to agree to a requested restriction.** We will inform you of our decision or your request.
- Obtain a paper copy of this notice of privacy practices upon request.
- Inspect and obtain a copy of your medical information, in most cases.
- Request in writing*, an amendment to your record in you believe the information in your record is incorrect or important information is missing. We could deny your request to amend a record if the information was not created by us, maintained by us, or if we determine the record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- Obtain an accounting of disclosures starting who and where your health information has been disclosed for purposes other than treatment, payment, health care operations (TPO) or where you specifically authorized a use or disclosure in the past six (6) years, but not prior to April 14, 2003. The request must be in writing and state the time period desired for the accounting*. After the first request, there may be a charge.
- Request that medical information about you be communicated to you in a confidential way or at an alternative location but you must specify how or where you wish to be contacted.

* All written requests or appeals should be submitted to our Privacy Official listed at the bottom of this notice.

CHANGES TO THIS NOTICE

SWAT has the right to change this notice at any time. We have the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will also post a copy of the current notice at our SWAT location.

The notice will contain the effective date. In addition, you may request a copy of the current notice each time you register with SWAT for treatment or health care services.

COMPLAINTS

If you have questions or would like additional information or if you believe your privacy rights have been violated, you can contact SWAT Privacy Officer via mail or call (806) 799-7928. You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201. Filing a complaint will not negatively affect the treatment or coverage that you receive.

PRIVACY OFFICIAL

Name: Chad R. Southard
Privacy Officer
Address: 3509 22nd Street
Lubbock, TX 79410
Phone: (806) 799-SWAT

SWAT Surgical
Associates, L.L.P.

*Aviso de
Atencion Privada*

EL SWAT INFORME DE ATENCION PRIVADA

Este aviso explica como su informacion medica pueda ser utilizada y compartida, y como ud puede tener acceso a dicha informacion.

POR FAVOR LEALO CON CUIDADO

QUIENES DEBEN LEER ESTE AVISO?

El SWAT Surgical Associates, L.L.P. (SWAT) brinda atención medica a nuestros pacientes y clients en sociedad con otros profesionales y organizaciones. La Atención Privada de este aviso debe ser aplicada por:

- Cualquier profesional autorizado del SWAT que tenga acceso a su archivo.
- Todos los departamentos y unidades de este Grupo.
- Cualquier miembro de un grupo de voluntarios que este autorizado por SWAT para ayudarlo.
- Todos los empleados, personal medico y cualquier otro personal de SWAT.
- Toda empresa asociada con nosotros con quienes compartimos información acerca de la salud.

NUESTRA RESPONSABILIDAD REFERENTE A SU INFORMACION MEDICA

Sabemos que su información medica es personal. Estamos comprometidos en proteger la privacidad de esta información. En el esfuerzo de brindarle a usted una atención medica de alta calidad y de cumplir con las especificaciones legales, nosotros nos comprometemos a:

- Mantener privada su información medica.
- Proporcionarle una copia de este aviso.
- Cumplir con los términos de este aviso.
- Notificarle en caso de no poder cumplir con lo solicitado por usted.
- Ajustarnos a algún pedido razonable de su parte, en la forma de brindarle información respecto a su salud mediante formas y/o lugares.

COMO PODEMOS USARY COMPARTIR SU INFORMACION MEDICA

Nosotros podemos usar y compartir su información médica para su **tratamiento** (como el enviar su información medica a un especialista como parte de una referencia); **para obtener el pago por tratamiento** (como enviar facturas de cobro a su compañía de seguro o Medicare); y para **apoyar nuestras decisiones sobre el cuidado de la salud** (como comparar la información del paciente para mejorar métodos de tratamientos).

EJEMPLOS DE INFORMACION DE TRATAMIENTOS, PAGOS U OPERACIONES DEL CUIDADO DE LA SALUD (TPO).

Usaremos la información de su salud para brindarle tratamiento.

Por ejemplo: La información que recibe una enfermera, médico u otro miembro del equipo encargado del cuidado de su salud, será archivada y usada para determinar su tratamiento. También proveeremos a su médico u otra persona encargada de su salud con copias de su archivo para ayudarlos en su tratamiento.

Usaremos la información de su salud para el pago.

Por ejemplo: La factura puede ser enviada a usted o a su compañía de seguros. La información que acompaña la factura puede incluir información que lo identifique, su diagnóstico, procedimientos, medicinas y accesorios usados en su tratamiento. Usaremos la información de su salud para tratamientos regulares del cuidado de la salud.

Por ejemplo: Miembros del personal médico, personal del departamento de riesgo y calidad del Grupo podrán usar la información de su archivo de salud para determinar el cuidado y tratamiento de su caso o de otros similares, Esta información será, desde luego, usada en el esfuerzo de mejorar continuamente la calidad y efectividad del cuidado de la salud y servicios que brindamos.

COMO USARAN MI INFORMACION

- Nos comunicaremos con usted para **recordarle la cita**, o para comunicarle o recomendarle las **opciones de posibles tratamientos, alternativas, beneficios relacionados con la salud o servicios** que la puedan interesar.
- Nos comunicaremos con usted para pedirle apoyo para ciertas **actividades caritativas. ***Usted tendrá la oportunidad de rechazar o recibir esta información desde el primer contacto con nosotros***.**
- Podemos compartir su información médica, con un miembro de familia, amigo o cualquier persona que se involucre en su atención.

Nosotros podemos usar y compartir su información médica **sin** su autorización por muchas razones. Estamos supeditados a ciertos requisitos que nos permiten dar información médica sin su autorización y por las siguientes

Investigación. Podemos usar y mostrar su información médica, con el propósito de investigación. Todos los estudios de investigación, están sujetos a un proceso especial de aprobación, a través del comité apropiado del SWAT.

Ley. Podemos compartir información médica, cuando lo requiera la ley. Ya sea en casos en que sea requerido por un oficial, por circunstancias específicas, o en respuesta a una orden judicial o administrativa.

Salud pública. Podemos compartir información acerca de su salud a las autoridades legales o de salud pública, encargadas de prevenir y controlar enfermedades, lesiones, invalidez, abuso del niño o negligencia, etc. Como lo ordena la ley.

Negocios asociados. Hay algunos servicios que se brindan en nuestra organización a través de contratos con asociados (ej: podemos mostrar información médica a una compañía que cobra a las compañías de seguro en nuestro nombre, y nos permite a través de ella, obtener el pago de la atención médica que le brindamos). Para proteger sus datos médicos le pedimos a nuestros asociados, que cuiden apropiadamente su información.

Aviso. Podemos usar o compartir información para avisar o ayudar a un miembro de la familia, representante personal o a otra persona encargada de su cuidado, de su paradero y estado general.

Empresarios funerarios. Podemos mostrar la información de salud a empresarios funerarios, que actúen conforme a ley, para cumplir sus obligaciones.

Donación de órganos. Conforme a ley, podemos mostrar la información de su salud, a organizaciones que gestionan la donación de órganos, u otras entidades, con el propósito de donar tejido o para transplantes.

Administración de Alimento y Droga. (FDA). Podemos mostrar al FDA, la información de salud relacionada a eventos adversos.

Indemnización de Trabajadores. Podemos compartir su información de salud, si fuera necesario, para cumplir con la ley relacionada con la indemnización de los trabajadores u otros programas similares establecidos por la ley.

Instituto Correccional. Si se encuentra preso en un instituto correccional, podemos mostrar al instituto o a sus representantes, información necesaria para el cuidado de su salud y/o para la salud y seguridad de otras personas.

Requisitos del Estado. Muchos estados tienen como requisito, informar las actividades básicas de la población, relacionadas con mejoramiento de la salud o la reducción del costo del cuidado de la salud.

Acuerdos para Organizar el Cuidado de la Salud. El hospital y los miembros del personal de SWAT, han organizado este aviso y se lo presentan a usted. Compartiremos la información cuando sea pagos y operaciones al cuidado de la salud. Los médicos y personal de salud pueden tener acceso a la información de salud privada, que se encuentra en sus oficinas, para revisar los tratamiento que se han usado anteriormente que puedan afectar el tratamiento actual.

OTROS USOS DE INFORMACION MEDICA.

Si se presentara otra situación que no esta cubierta en este aviso, le pediríamos que nos de una autorización por escrito antes de usar o compartir su información medica. Si usted decide autorizarnos para usar y compartir su información medica, mas tarde puede revocar dicha autorización, notificándonos por escrito de su decisión, a excepción de la acción que ya se haya tomado, basada en el hecho de que ya teníamos su autorización.

SUS DERECHOS RELACIONADOS CON LA INFORMACION MEDICA.

Aunque su archivo de salud sea propiedad del SWAT, usted tiene el derecho de:

- Pedir una restricción, por escrito*, en algunos usos o publicaciones de su información medica para tratamientos pagos o decisiones del cuidado de la salud, con la excepción de situaciones de emergencia. Nosotros tomaremos en cuenta su pedido, **pero no estamos legalmente obligados a estar de acuerdo con el pedido de restricción.** Le informaremos cual fue nuestra decisión a su pedido.
- Obtenga una copia escrita de este aviso de nuestra política privada.
- En la mayoría de los casos, obtenga e inspeccione una copia de su información médica.

- Pida una modificación en su expediente por escrito*, si usted considera que la información no es correcta o falta información importante. Nosotros podemos negar su pedido de modificar su expediente si la información no fue creada o sostenida por nosotros, o si determinamos que la información en su archivo es correcta. Usted puede apelar, por escrito, la decisión nuestra de no modificar sus datos.
- Obtenga un legajo de las veces que su información médica ha sido compartida con otro propósito que no sea tratamiento, pago, operaciones del cuidado de la salud o en donde dio específicamente autorización para el uso o la publicación durante los últimos seis (6) años, no antes del 14 de abril de 2003. El pedido debe ser por escrito, y debe especificar el periodo de tiempo deseado*. Puede haber un cargo monetario después del primer pedido.
- Solicite que su información médica se le comunique en forma confidencial o en el lugar que usted escoja como alternativa. Usted debe especificar cómo y dónde quiere ser contactado.
- **Todos los pedidos por escrito o las apelaciones deben entregarse al Oficial de Atención Privada, su nombre se encuentra al pie de la página.**

MODIFICACIONES A ESTE AVISO

SWAT tiene el derecho de cambiar este aviso en cualquier momento. También tiene el derecho de revisar o cambiar el aviso vigente sobre información médica que ya tenemos de usted así como de cualquier información que recibamos en el futuro. Vamos a exhibir una copia del aviso actualizado en cada localización de SWAT. El aviso va a tener la fecha efectiva. Además, usted puede pedir una copia del aviso actual, cada vez que se registre en cualquier oficina de SWAT, para tratamiento o servicio del cuidado de la salud.

QUEJAS

Si usted tiene preguntas o necesita más información, o si piensa que sus derechos han sido violados, usted puede hablar con la Entidad Oficial Privada, por correo o llamando al 800-337-7040.

También puede presentar una queja por escrito al Departamento de Salud y Oficina de Servicios Humanos y Derechos Civiles ubicada en:

200 Independence Avenue, S.W.,

Washington, DC 20201. Su queja no afectará el servicio de salud que se le brinde.

Oficial de Atención Privada

Nombre: Chad R. Southard

Privacy Officer

Dirección: 3509 22nd Street

Lubbock, TX 79410

Teléfono: (806) 799-SWAT