

**Legacy Male Health Institute, P.A.**  
5616 Warren Parkway, Suite 101  
Frisco, Texas 75034 • 972-612-7131

**PATIENT INFORMATION**

NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_  
DATE OF BIRTH (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ SOC SEC NO. \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
HOME ADDRESS (Street) \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ MARITAL STATUS: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_  
PHONE: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
DRIVER'S LICENSE # \_\_\_\_\_ STATE OF ISSUE \_\_\_\_\_ EXP \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY CARRIER'S NAME \_\_\_\_\_  
CLAIMS MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ PPO \_\_\_ POS \_\_\_ EPO \_\_\_ HMO \_\_\_ IND \_\_\_ OTHER \_\_\_  
POLICYHOLDER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
DATE OF BIRTH (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ GROUP NAME \_\_\_\_\_  
SECONDARY CARRIER'S NAME \_\_\_\_\_  
CLAIMS MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ PPO \_\_\_ POS \_\_\_ EPO \_\_\_ HMO \_\_\_ IND \_\_\_ OTHER \_\_\_

**EMERGENCY CONTACT**

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
HOME ADDRESS (Street) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

## Legacy Male Health Institute, P.A. Notice of Privacy Practices

**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.**

Each time you have contact with a healthcare provider, a record of your visit is prepared. This record contains demographics, presenting signs/symptoms, results of the examination and tests, diagnoses, treatment and future care. Your medical record is the physical property of the medical practice, but you have certain rights to restrict some of the uses or disclosures of the information in your medical record. Legacy Male Health Institute, P.A., however, has the right to use and disclose the information contained in your medical record for the following:

### Uses and Disclosures

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to obtain reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Legacy Male Health Institute, P.A.. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition..

### Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

## **Legacy Male Health Institute, P.A. Duties**

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of Legacy Male Health Institute, P.A.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

## **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

## **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

## **Comments and Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Atten: Privacy Officer

**Legacy Male Health Institute, P.A.**

**5616 Warren Parkway, Suite 101**

**Frisco, Texas 75034**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

## **Effective Date**

This Notice is effective on or after April 14, 2003.

LEGACY MALE HEALTH INSTITUTE, P.A.

**Patient Acknowledgement and Consent Form**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that Legacy Male Health Institute, P.A. (LMHI) reserves the right to modify the privacy practices outline in the notice and that I may contact LMHI to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that LMHI restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time.

**I also wish to share my protected health information with my Spouse**

(or guardian): \_\_\_\_\_  
(Print Name)

**I have received, read and understand Legacy Male Health Institute, P.A. Notice of Privacy Practices prior to signing this consent.**

**Patient Name (print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship if not Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment & Consent, but was unable to do so as documented below:

Date:	Initials:	Reason:
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