PARAGON
Health Partners
PAIN - OBESITY - ADDICTION

Patient Name: _____ **Date:** _____

If you have an open Work Comp or Car Accident Please stop here and inform front Desk. We cannot file on your Medical Insurance

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ❑ PRMC ❑ Other_____ ❑ Family ❑ Friend ❑ PCP

❑ Facebook ❑ Instagram ❑ Other Website _____

Pain Description

Where is your **worst** area of pain located? _____

Does this pain radiate? ❑ Yes ❑ No. If so, where? _____

Please list any additional areas of pain: _____

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

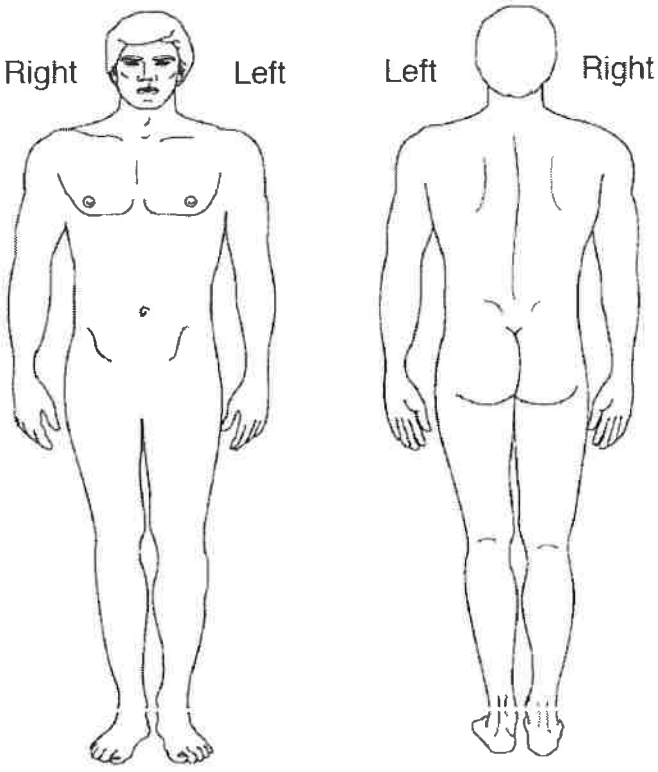
What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **average pain over the last month**? _____

Use this diagram to draw the location of your pain and check all of the following that describe your pain.



- ❑ Aching
- ❑ Cramping
- ❑ Dull
- ❑ Hot/Burning
- ❑ Numbness
- ❑ Shock-like
- ❑ Shooting
- ❑ Spasming
- ❑ Squeezing
- ❑ Stabbing/Sharp
- ❑ Throbbing
- ❑ Tingling/Pins & Needles
- ❑ Tiring/Exhausting

Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

❑ Enjoyment of Life	❑ Normal Work	❑ Sleep
❑ General Activity	❑ Recreational Activities	❑ Walking
❑ Mood	❑ Relationships with People	❑ Other: _____
❑ My goal is to resume normal activities		

In the past three months have you developed any new:

❑ Balance Problems	❑ Bladder incontinence	❑ Bowel incontinence	❑ Chills
❑ Difficulty Walking	❑ Fevers	❑ Nausea	❑ Vomiting

❑ Numbness/Tingling – Where?_____ ❑ Weakness – Where? _____

❑ **I HAVE <u>NOT</u> RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

What makes the pain worse? _____

_____

_____

What makes the pain better?_____

_____

_____

Diagnostic Tests and Imaging

ist the ost recent test(s) you have had that are related to your current pain complaints:

- ❑ MRI of the _____ Date: _____ Facility: _____
- ❑ X-ray of the _____ Date: _____ Facility: _____
- ❑ CT scan of the _____ Date: _____ Facility: _____
- ❑ EMG/NCV study of the _____ Date: _____ Facility: _____
- ❑ Ultrasound of the _____ Date: _____ Facility: _____
- ❑ Other diagnostic testing: _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ Physical Therapy ❑ Psychological Therapy ❑ Podiatrist Treatment

- ❑ Chiropractic
- ❑ Epidural Steroid Injection – (circle proper levels) Cervical / Thoracic / Lumbar
- ❑ Joint Injection – Joint(s)_____
- ❑ Medial Branch Blocks or Facet Injections – (circle proper levels) Cervical / Thoracic / Lumbar
- ❑ Pain Pump _____
- ❑ Radiofrequency Ablation – (circle proper levels) Cervical / Thoracic / Lumbar
- ❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
- ❑ Spine Surgery _____
- ❑ Trigger Point Injection
- ❑ Vertebroplasty / Kyphoplasty – Level(s) _____
- ❑ Other:

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Medications

Please list **ALL** of the medications you are taking, **Pain meds listed first.** Attach an additional sheet if necessary.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Please list ALL pain medications you have taken in the past and are now **not** taking.

_____

_____

_____

_____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat

- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Cardiovascular / Hematologic

- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker/Defibrillator
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke

Respiratory

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Exposure to mold

Gastrointestinal

- ❑ Bowel Incontinence/IBS
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal

- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression fracture

Genitourinary/Nephrology

- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic

- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological

- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Complex Regional Pain Syndroe

❑ **Other Diagnosed Conditions**

_____

_____

_____

_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the **date, type,** and any pertinent **details.**

_____

_____

_____

_____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Alcohol problems	Cancer	Diabetes	Drug problems	Abnormal bleeding	Headaches	Heart Disease	High blood pressure	Kidney disease	Liver disease	Rheumatoid arthritis/Lupus	Smoking	Stroke
Mother													
Father													

Other medical problems: _____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High school ❑ College ❑ Post-graduate

Are you currently working? ❑ Yes ❑ No What is/was your occupation?_____

Alcohol Use: ❑ Denies alcohol use ❑ Current alcohol use How much?_____
❑ History of alcohol abuse

Tobacco Use ❑ Denies tobacco use ❑ Current tobacco use How much? _____
❑Former tobacco user

Illicit Drug Use: ❑ Denies any Illicit drug use ❑ Currently using Illicit drugs Which? _____
❑ History of illicit drug use

Have you ever abused narcotic or prescription medications? ❑ Yes ❑ No; *If So*, which_____

Are you currently in remission for alcohol or any other addictions ❑ Yes ❑ No ❑ not applicable

Did anything specific happen to cause the pain? ☐ Yes ☐ No
If yes, please Describe:

Is the injury or pain the result of a work-related injury? Yes ☐ No ☐
Date of Injury? _____ Have you reported it to your employer? Yes ☐ No ☐

Is the injury or pain motor vehicle related? ☐ Yes ☐ No
Date of Injury? _____

Is there a lawsuit (pending or considered)? ☐ Yes ☐ No

Do you have a history of sexual abuse? ☐ Yes ☐ No
Do you have a history of physical abuse? ☐ Yes ☐ No
Do you have a history of emotional abuse? ☐ Yes ☐ No
If yes to any please describe: ☐ ☐

_____

Please check if you are allergic to ❑ Iodine or ❑ Tape

Are you allergic to latex? ❑Yes ❑No

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.
❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

What was the reaction? _____

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?
❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Allergies

Do you have any known drug allergies? ❑Yes **Allergic Reaction Type (What Happens?)**

If so, please list all medications you are allergic to: ❑No
Medication Name

Goals of Treatment

Please explain your goals of treatment_____
_____
_____
_____

If on opioids, **please explain how they help you**, what they allow you to do if you were not taking them otherwise_____
_____
_____

Review of Systems

Mark the following symptoms that you **currently** suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional: ❑ Weakness ❑ Fatigue ❑ Weight gain ❑ Weight loss ❑ Fever ❑ Chills ❑ Night sweats

Eyes: ❑ Recent visual changes ❑ Eye glasses/contact lenses ❑ Double vision

Ears/Nose/Throat: ❑ Dental Problems ❑ Ear aches ❑ Hearing probles ❑ Nosebleeds
❑ Recurrent sore throats ❑ Ringing in the ears ❑ Sinus problems

Cardiovascular: ❑ Chest pain ❑ Irregular heartbeat ❑ Murmur ❑ Rapid heartbeat ❑ Blood clots
❑ Swollen extremities ❑ Palpitations ❑ Fainting

Respiratory: ❑ Cough ❑ Shortness of Breath on Exertion/Effort ❑ Wheezing ❑ Shortness of breath at rest

Gastrointestinal: ❑ Acid reflux ❑ Abdominal cramps ❑ Constipation ❑ Diarrhea ❑ Vomiting
❑ Coffee ground appearance in vomit ❑ Dark and tarry tools

Genitourinary/Nephrology: ❑ Blood in Urine ❑ Decreased urine flow/Frequency/Volume ❑ Flank pain
❑ Erectile dysfunction ❑ painful urination ❑ Incontinence

Integumentary/Skin: ❑ Change in skin color ❑ Rashes ❑ Puritis ❑ Dry skin

Musculoskeletal ❑ Joint swelling ❑ Back pain ❑ Muscle spasms ❑ Joint pain ❑Neck pain
❑ Pelvic pain ❑ Joint stiffness

Psychiatric: ❑ Depressed mood ❑ Anxiety ❑ Stress ❑ Suicidal Thoughts

Endocrine: ❑ Heat Intolerance ❑ Cold Intolerance ❑ Hair changes ❑ Excessive thirst

Neurological: ❑ Dizziness ❑ Seizures ❑ Headaches ❑ Numbness/tingling ❑ Memory loss
❑ Difficulty with speech ❑ Uncoordination ❑ Difficulty walking

Hematologic/Lymphatic: ❑ Easy bruising ❑ Easy bleeding ❑ Impaired wound healing ❑ Lymphadenopathy

Allergic/Immunologic: ❑ Recurrent infection ❑ Hives ❑ Swelling ❑ Itching eyes or nose

PARAGON
Health Partners

Medical Record Release of Information

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____)_____ Fax (____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name:
PARAGON HEALTH PARTNERS/PARAGON PAIN & REHABILITATION
Address 2895 Lewis Lane Paris, TX 75034
Phone (972)-203-3600 Fax (972) 203-3601 Email: info@paragonphp.com

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual, the individual reaching the age of majority, or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

Patient Name

Date:

Consents	Initital
Consent For Treatment: I hereby consent to the treatment by the providers at Paragon Health Partners and its employees or designees. I auathorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.	
Consent for Medication History: I authorize Paragon Health Partners and its employees or designee to access my medication history via PMP portal and from participating pharmacies that Paragon Health Partners request medication History.	
Consent of Picture for Electronical Medical Record Chart: I understand and consent and authorize that my photo is taken for my Electronical medical record chart. If I am being treated for obesity medicine this picture will be attached to my progress note.	
Authorization for Release of personal health Information: I aurthorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or the purposes of conducting the healthcare operations of Paragon Health Partners. I authorize Paragon Health Partners to release any information required in the process of applicationts ofr financial coverage for the services rendered. This authorization provides that Paragon Health Partners may release clinical information related to my diagnosis and treatments for pain management, addiction medicine, alcohol or opioid, street drugs use, obesity medicine, which may be requested by my insurance or its designated agent.	
Assignment of Insurance Benefits/Payment Gurantee/Collection Fee: I authorize payment to be made directly to Paragon Health Partners, Paragon Primary Care, Paragon Pain & Rehabilitation, and/or any of its providers. For insurance payment payable to me. I understand that I am financially responsible to practice for any non-coverred servcies , as defined by my insurer. I understand that if my account balance becomes overdue if may be referred to collection agency. I understand payment is due at time of service.	
Privacy Policy: I acknowledge having received Paragon Health Partners, "Notice of Privacy Practices" My rights including the right to see a copy of my medical records, to limit disclosure of my health information, and to request an amendment to my record, is explained in the policy. I understand that I may revoke in writing my consent fo release of my healthcare information, excep to the extent Paragon Health Partners has already made disclosures with my prior consent.	
Disclaimer: By Typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this paperwork from Paragon Health Partners.	
Payment Policy All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps	
Late/No Show/Cancellation Fees: **Late is considered arriving for New Evaluation less than 30 minutes prior to appointment time. You can be rescheduled and will be charges a $50.00 Fee. Late for a Follow Up over 5 minutes will be rescheduled and charged a $25.00 Fee. A missed appointment, reschedule less than 48 hours prior will result in a $50.00 Fee, and a $25 fee if it is a follow up appointment . Telemedicine or Office Appointment.**	

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

Patient Name (Printed)

Responsible Party (Printed) (If patient is a minor or dependent adult)

Patient Signature Date

New Patient Demographic Information

- ☐ Driver's License or State Issued Photo ID.
- ☐ Photocopy of the front and back of your insurance card.

Preferred Pharmacy I understand I am only allowed to use ONE pharmacy by Paragon		☐ Yes	☐ No
Pharmacy Name	Pharmacy Location		

Patient Information

Name (First, Middle, Last)		Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Employer (or parent/guardian employer if patient is a minor)				Work Phone	
Primary Care Provider (where you go for your routine medical care)					

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Medicare Patient: Are you enrolled in Chronic Care Management with PCP?

Medicare Patient: Are you enrolled in Remote Patient Monitoring with any Physician?

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.
2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.
3. I understand that if my insurance(s) require a referral from my primary care physician, Norberto Vargas, M.D or JP Benavides, D.O. at Paragon Pain & Rehabilitation, LLP, must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).
4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.
5. I authorize direct payment by my insurance company(s) to Paragon Pain & Rehabilitation, LLP.

Signature

HIPAA NOTICE OF PRIVACY PRACTICES

Paragon Pain Rehabilitation LLP ("Paragon") is committed to maintaining the privacy of your health information. We understand that health information about you is personal. We are required by law to maintain and protect health information about you. We are required by federal law to provide you with this Notice of Privacy Practices ("Notice") that describes how health information that we maintain about you may be used or disclosed. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

This Notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Your Health Information
We are permitted to use and disclose your health information under a variety of circumstances. Some of the reasons that we may use or disclose your information include:

- For Treatment: We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your name, age, possible diagnosis, and other information required to obtain laboratory testing.
- For Payment: We can use and disclose your health information to bill and get payment from you, your health insurers or other entities. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you.
- For Health Care Operations: We may use and disclose your health information for our operations. For example, we may need to use your information when in the course of quality assurance or utilization review activities. We may also combine medical information about our patients to decide what services we should offer or to see where we can make improvements..
- Use or Disclosure Required By Law. We may use or disclose your health information to the extent such use or disclosure is required by law.
- Health Agency Oversight Activities. We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- Law Enforcement. We may disclose your health information for law enforcement purposes.
- To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- Public Health Risks: We may disclose health information about you for public health activities.
- Workers' Compensation. We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- To Respond to Lawsuits and Legal Actions: We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- Business Associates: We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health care information to a family member or friend involved in your care or payment for your care.
- Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.
- Appointment Reminders and Communications. We may use and disclose your health information and the contact information you provide us with to contact you with appointment reminders or other health-related communications, including via email, text message or telephone or mail. While email or text messages may not be encrypted or secure and could be intercepted in transit, we will assume you understand these risks if you provide us with your mobile telephone number or email address and that you consent to us communicating with you in this manner.

Other Uses of Your Health Information
Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Your written, signed authorization is required before Paragon may use or disclose health information containing psychotherapy notes, if Paragon intends to use your health information for marketing purposes, or for the sale of your health information. You may revoke this permission for any of those purposes requiring authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in a designated record set. We may charge a reasonable, cost-based fee. We may require you to submit your request in writing.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. We will provide you one accounting of disclosures each year free of charge but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. We may require you to submit your request in writing.
- Right to Amend: If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our organization. We may require that you submit a request in writing and provide a reason to support the requested amendment.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We may require you to submit such a request in writing. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. However, we must agree to the request for a restriction if the request involves a disclosure about your health information to a health plan (1) when the disclosure regards carrying out payment or health care operations (and is not otherwise required by law), and (2) the health information solely pertains to health care that you, or a person other than a health plan, has paid to Paragon in full.
- Right to Request Confidential Communications: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Changes to this Notice.

We are required to abide by the current version of this Notice, and we reserve the right to change this Notice. The revised or changed Notice will be effective for health information we already have about you as well as any information we receive in the future. The new notice will be available upon request, in our office and on our website.

Complaints

If you believe that we may have violated your privacy rights, or you disagree with a decision about your health information, you may file a complaint with us by contacting the Privacy Officer at the address listed below or with the Secretary of the Department of Health and Human Services. You will not face retaliation for filing a complaint.

Privacy Officer

For further information, please contact our Privacy Officer, Karen McNerney at:

[PO Box 1200 Colleyville, TX 76034]

Effective Date: June 15, 2022

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Paragon's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Paragon may use and disclose your health information. I understand that the Notice is subject to change.

_____	_____
Name of Individual (Printed)	Signature of Individual
_____	_____
Signature of Personal Representative	Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a a minor)

Date Signed _____/_____/_____