PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (___)_____ Day Phone: (___)_____ Email: _____

Race_____ Language_____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ _____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (___) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ _____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (___) _____ (___)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (___) _____ (_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (___) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name:_____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accord-ingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

Patient Demographic & Information Sheet

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

Patient Name:_____ Age: _____Height:_____ Weight:_____

CHIEF COMPLAINT (Please describe the main reason for your visit today)_____

What are we seeing you for today? Left / Right (body part) _____

Date of Onset: _____

Was there an injury? YES NO
Was it work related? YES NO Have you filed a claim? YES NO
Was it sports related? YES NO Did you bring a claim form? YES NO
Was there a car accident? YES NO Do you have a lawyer? YES NO
Where did the incident occur? (Geographical location, not body part)_____

DID YOU BRING ( ) X-RAYS ( ) MRI ( ) OTHER REPORT _____

Please give the details of your chief complaint: _____

_____

How long have your symptoms been present?

Was it an acute (new) injury? (circle one) yes no or are you having chronic (old) symptoms? (circle one) yes no

Are symptoms intermittent occasional constant rare mild moderate severe incapacitating

Circle all that apply pain stiffness swelling instability weakness numbness/tingling bruising locking

Aching burning dull piercing sharp throbbing radiating

What makes symptoms **worse**? Bending Stairs Lifting Movement Pushing Sitting Standing Walking

What makes symptoms **better**? Brace Elevation Exercise Heat Ice Massage Rest Stretching Other:

What medications have you had for treatment?

What other treatments or tests have you had for this **current** problem? Circle all that apply

X-rays MRI CT scan Bone Scan EMG Surgery Splinting/Bracing Physical Therapy Chiropractic treatment

Other diagnostic tests:

Have you had any injections for this problem? YES NO If yes, then what type?

Were previous treatments helpful to any degree? If so what?

On scale of 1-10 (10 being most severe) circle # that best describes your pain 1 2 3 4 5 6 7 8 9 10

Do you have any pain in your joints at night? YES NO If so which one?

What activities do you enjoy?

Are your complaints affecting your ability to exercise or generally be active? Yes No

Do you know of any other reason why you should not do physical activity?

Since this problem began is the problem (circle): Improving Worsening Unchanged

When are your problems most severe? Morning Afternoon Evening Nighttime Consistent all day
Your goals for treatment are: _____

MEDICAL INFORMATION:

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS OR ILLNESSES? (Please answer with a check circle to each or check/circle NONE)

( ) Alzheimer's Disease	( ) Depression	( ) Heart Attack	( ) Lupus
( ) Anemia	( ) Diabetes	( ) Obesity	( ) Thyroid disease
( ) Rheumatoid Arthritis	( ) Drug abuse	( ) Osteoporosis	( ) Valvular disease
( ) Osteoarthritis	( ) High Cholesterol	( ) Parkinson disease	( ) Poor Circulation
( ) Asthma	( ) Fibromyalgia	( ) PUD / Ulcers	( ) Kidney Failure
( )Cancer (List Below)	( ) Fracture	( ) Psoriasis	( ) Diverticulitis
( ) Congestive Heart Failure	( ) Gout	( ) Renal or Kidney disease	( ) Irregular heart beat
( ) COPD / Emphysema	( ) Headaches, migraine	( ) Scoliosis	( ) Bronchitis
( ) Heart Disease	( ) Heart Stent	( ) Seizures	( ) Pneumonia
( ) Crohn's Disease	( ) Hepatitis / liver disease	( ) Sleep apnea	( ) Tuberculosis
( ) Bleeding Disorder	( ) High Blood Pressure	( ) Spinal stenosis	( ) Multiple Sclerosis
( ) Blood Clots / DVT	( ) HIV/AIDS	( ) Degenerative Disc	( ) Neuropathy
( ) Degenerative Disc	( ) Inflammatory bowel disease	( ) Stroke	( ) Schizophrenia

Other Medical Conditions/Illnesses not listed above: _____

Please give details if you answered "yes" to any of the above: _____

PREVIOUS SURGERY (Please answer with a check/circle to each or check/circle NONE)

( ) NONE	( ) Blood transfusion	( ) Gastric Bypass	( ) Lumpectomy
( ) ACL surgery	( ) Coronary Bypass (CABG)	( ) Hemorrhoidectomy	( ) Mastectomy
( ) Abdominal Surgery	( ) Cardiac Pacemaker	( ) Hernia repair	( ) Kidney removed
( ) Amputation	( ) Cardiac Valve	( ) Hip Replacement	( ) Kidney Transplant
( ) Angioplasty or Heart stent	( ) Carotid Surgery	( ) Hysterectomy – Complete	( ) Parathyroidectomy
( ) AV Fistula Graft	( ) Carpal tunnel release	( ) Hysterectomy – Partial	( ) Lung removed
( ) Appendectomy	( ) Cataract	( ) Interv. Pain injection	( ) Rotator Cuff Repair
( ) Arthroscopy	( ) Gallbladder	( ) Knee Arthroscopy	( ) Thyroidectomy
( ) Back Surgery	( ) Colon Resection	( ) Knee Replacement	( ) Tonsillectomy
( ) Breast Surgery	( ) Colostomy	( ) LASIK	( ) Surgical Complication

PREVIOUS SURGERY (Please list and give dates): _____

PLEASE CHECK BELOW OR LIST ANY MEDICAL CONDITIONS THAT ARE IN YOUR FAMILY: _____

( ) NONE	( ) Blood clot (DVT)	( ) Diabetes – Type 2	( ) Neurologic Disorder
( ) ADD / ADHD	( ) Breast Cancer	( ) Drug abuse	( ) Obesity
( ) Alcoholism	( ) Cancer	( ) GI Bleed	( ) Osteoporosis
( ) Allergies	( ) Cardiovascular Disease	( ) Reflux (GERD)	( ) Parkinson's disease
( ) Alzheimer's disease	( ) Colitis	( ) High Cholesterol	( ) Poor circulation (PVD)
( ) Anemia	( ) Congestive heart failure	( ) Genetic disease	( ) Renal or Kidney Disease
( ) Rheumatoid Arthritis	( ) COPD	( ) Gout	( ) Seizure Disorder
( ) Osteoarthritis	( ) Coronary artery disease	( ) Hypertension	( ) Stroke (CVA)
( ) Asthma	( ) Heart Attack (MI)	( ) Mental illness	( ) Thyroid Disorder
( ) Atrial Fibrillation	( ) Depression	( ) Migraines	( ) Multiple Sclerosis
( ) Blood disorder	( ) Diabetes – Type 1	( ) Muscle disease	( ) Prostate Cancer

REVIEW OF SYSTEMS WORKSHEET

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Circle all that apply)

chills	vision loss	abdominal pain	painful urination	insomnia
fatigue	chest pain	constipation	frequent urination	muscle weakness
fever	cough	diarrhea	bloody urination	numbness/tingling
night sweats	shortness of breath	heartburn	cold intolerant	stiffness
weight gain	wheezing	loss of appetite	heat intolerant	joint pain
weight loss	leg swelling	nausea	unusual stress	joint swelling
blurred/double vision	fainting	vomiting	anxiety	bleeding
hearing loss	irregular heart beat	change in urination	depression	bruising

MEDICAL INFORMATION CONTINUED:

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No Are you allergic to latex: Yes No Contrast Dye Allergy: Yes No

Are you allergic to shellfish: Yes No Betadine or Iodine Allergy: Yes No

Please list all known drug allergies and the type of reaction. (Example rash, nausea, etc.) PLEASE BE SPECIFIC

_____

_____

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

_____

_____

_____

_____

_____

TOBACCO USE: ( ) Cigarettes: _____ packs per day _____ years ( ) Snuff/Chewing tobacco ( ) Non-Smoker

ALCOHOL USE: _____ drinks per day Marital Status: Single Married Divorced Widowed

Employment Status: Employed Unemployed Retired Disabled Other (Please Explain) _____

Employer: _____ Occupation: _____

PRIMARY CARE PHYSICIAN'S NAME: _____ Phone: (_____) _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Address: _____ Phone:(_____) _____

PREVIOUS TREATMENT WORKSHEET

To help us determine the best treatment for you as based on your personal preferences and treatment goals, which of the following have you used or undertaken for at least three (3) months in duration? (Check or circle all that apply)

( ) relative rest
( ) modification of your activities
( ) weight loss
( ) home exercises)
( ) use of a cane or walker
( ) Anti-inflammatory medication
( ) physiotherapy modalities (i.e. ice, ultrasound, massage, TENS unit)
( ) Supervised physical therapy or chiropractic exercises,
( ) oral pain medications,
( ) bracing,
( ) steroid injections
( ) other injections (gel, lubricant, or viscosupplementation)

SIGNATURE of PATIENT: _____ DATE: _____

BONE & JOINT CLINIC
TEXAS HEALTH CARE FORT WORTH

OFFICE PROCEDURES

The physicians and staff of Texas Health Care, P.L.L.C. would like to welcome you as a new patient. It is our sincere desire to offer you the best medical care available in a friendly and courteous manner. If at any time you have any questions regarding a part of the services you receive here, please do not hesitate to ask a member of our staff. General information regarding the procedures of Texas Health Care, P.L.L.C. are as follows:

OFFICE HOURS

Telephone: 8:30 a.m. - 5:00 p.m.
Reception: 8:00 a.m. - 5:00 p.m.
Answering Service - All other times, 24 hours per day, 7 days per week.

TELEPHONE CALLS

The telephone operator directs all calls to the appropriate department. If you require an appointment or wish to speak with medical records/billing, etc., please ask for that department when the phone is answered. For all calls to the physicians and/or nurse, please give the telephone operator your name and a telephone number where you may be reached. A physician or nurse will return your call between patient appointments, usually at the lunch break and end of day times.

APPOINTMENTS

All patients require an appointment before being seen. In an urgent/emergency situation, ask to speak with a nurse regarding when a physician may see you. Please give 24 hours notice when canceling an appointment.

PRESCRIPTION REFILLS

For a refill of your medication, please call the pharmacy. They will call us with all pertinent information. Allow 24 hours response time for these requests. No refills will be made after hours or on weekends.

INSURANCE

The staff will file for your insurance benefits on your behalf. However, all charges are the responsibility of the patient. Any unpaid insurance claims after 60 days will be billed to the patient.

WORKERS COMPENSATION

The staff will coordinate worker's compensation benefits between your employer and insurance carrier on your behalf. However, should the claim be ultimately denied as not an on the job injury, you will be responsible for all outstanding charges.

CO-PAYS/DEDUCTIBLES

All co-payments, deductible amounts and non-covered services for office visits are due at the time service is rendered. If you are scheduled for a surgical procedure, the staff will contact your insurance carrier to determine the approximate amount that will be due from the patient. You will be notified and those amounts will be due prior to the surgery date.

SURGICAL ASSISTANT

The physicians of Texas Health Care, P.L.L.C. utilize the services of a Certified Operating Room Technician on most surgical procedures. A separate charge will be made. These services may or may not be covered by your insurance carrier.

REFERRALS

If your insurance requires a referral from your primary care physician, please call your doctor to obtain that referral each time you are scheduled to be seen. Referrals are the responsibility of the patient and if one is not available at appointment time, rescheduling will be necessary.

DISABILITY/FMLA/OTHER INSURANCE FORMS

The staff will complete forms for disability/FMLA/or other insurance. There will be a fee for each form, each time it is completed. The fee is payable at time of request. No billing will be made. 7-10 working days are required for completion.

MINORS

ALL minors under the age of 18, each time they are seen, must be accompanied by a parent or guardian who is legally allowed to give medical consent.

HANDICAP PARKING

Forms for handicapped parking will be completed at no charge. Please allow 12-14 days.

I have read and understand the procedures of Texas Health Care, P.L.L.C.

_____ (Patient or Legal Guardian Signature)

AUTHORIZATION TO PERFORM MEDICAL SERVICES AND ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize Texas Health Care, its affiliated physicians, nurses and staff to perform all necessary medical services in connection with my physical condition.

I hereby assign to Texas Health Care, all of my rights and benefits under my health insurance policy/plan, including my right, if any, to recover statutory damages, punitive damages, attorney's fees, court costs and interest.

I understand that I am responsible for charges not covered or reimbursed by my insurance carrier and/or its agents. I agree, in the event of non-payment or partial payment, to pay the outstanding balance owed to Texas Health Care. Patient understands that if he/she does not pay the outstanding balance owed Texas Health Care. Texas Health Care has the right to file suit against the patient as well as his/her insurance provider. If Texas Health Care is forced to file suit, it will seek recovery of the balance owed, judicial interest, court costs and attorney's fees. Patient understands that, by taking an assignment of insurance benefits, Texas Health Care is not releasing the patient from payment for medical services and products provided by Texas Health Care.

I authorize my insurance carrier to release information regarding my coverage to Texas Health Care ("the Clinic"). I also authorize agents of any hospital, treatment center or previous physicians to furnish the Clinic copies of my medical history, services or treatment. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purpose of internal audits, research and quality assurance reviews within the Clinic.

This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Texas Health Care.

I hereby appoint Texas Health Care as my attorney-in-fact (power of attorney) to:

1. Provide any information in the possession of Texas Health Care to my insurance carrier for the purpose of obtaining insurance proceeds;
2. To sign and/or complete any forms or documents necessary to present/collect from my insurance carrier/plan; and
3. To endorse any benefit checks.

I have read the above statements and accept the terms. A duplicate of this statement .is considered the same as the original.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature/Relationship Date

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ○ OK to leave a message with detailed information
  - ○ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ○ OK to leave message with detailed information
  - ○ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

- If you have health insurance coverage and personally pay, out-of-pocket, in full for medical services provided, you may request that we not submit any information regarding these services to your insurance carrier.
- To request this restriction, notify the front desk of the physician's office. You will be provided with a separate form documenting this request. Please give or send the request to the Practice Team Liaison in this office.

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

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 below.

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

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- 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 provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of 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. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

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 below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If 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 know have the incorrect information.

Accounting of Certain Disclosures

The 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 you or your representative. Please submit any request for an accounting to the person listed below. 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.

Appointment Reminders, Treatment Alternatives, and Other Health-related 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.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

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.

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:

Jason Copling, Privacy Officer
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
jcopling@txhealthcare.com

This notice is effective on the following date: March 1, 2013.

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.

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