Starside Pediatrics

1518 Legacy Drive, Suite 110
Frisco, TX 75034

Patient General Information

Last Name		**First Name**		**Middle**
Nickname		**Prefix**	**Suffix**	**Birth/Maiden Name**
DOB / /	**Gender** Male ⬭ Female ⬭	**SSN** _ _		**EMAIL**
Street Address		**City, State, Zip**		
Home Phone	**Work Phone**		**Cell Phone**	
Preferred Pharmacy Location			**Pharmacy Phone Number**	

Parent Information

Parent/Guardian #1		**DOB** / /	**SSN** _ _
Drivers License Number/Issuing State		**Exp. Date**	**Email**
Home Phone	**Work**		**Cell**
Street Address	**City, State, Zip**		
Parent/Guardian #2		**DOB** / /	**SSN** _ _
Drivers License Number/Issuing State		**Exp. Date**	**Email**
Home Phone	**Work**		**Cell**
Street Address	**City, State, Zip**		

Insurance Information

Guarantor First Name	**Guarantor Last Name**	**DOB**	**SSN**
Insurance Company	**Group Number**	**Policy Number**	**Effective Date**
Claims Mailing Address			**Phone**

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Financial Policy

Patient Name: _____ **DOB:** _____

Patients with Insurance

Parents/Guardians of patients are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Co-payments and anticipated coinsurance amounts will be collected at the time of check-in and will be expected prior to services being rendered. Due to the rise in deductible plans, we will be asking for payment at the time of service. Beginning February 1, 2018 if you have a deductible, and have not met it, we will charge $75 at the time of your appointment. Once your insurance makes adjustments, we will send a statement with your remaining balance. If you do not have insurance, full payment will be due at the appointment. If you are unable to pay at the time of service, please inform us before your appointment. We will make every effort to work with you at that time. If a parent/guardian is unaware of their deductible or coinsurance amount, we will bill the insurance company as a courtesy. Any remaining balance should be taken care of within one (1) month's notice from the insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, or your family has an outstanding balance, you must notify the office to make arrangements in advance of each office visit.

Patients without Insurance

Parents/Guardians of patients are responsible for making payment for care at each patient visit. If payment cannot be made at each visit, you must notify the office to make arrangements in advance of each office visit.

Patients without their Insurance Card or New Insurance

Parents/Guardians of patients are responsible for making payment for care at each patient visit if the insurance cannot be verified with your insurance company before leaving the office. You must present your card at each visit per your insurance company and you must notify us promptly of any change in you or your child's insurance status.

Missed Appointments/Medical Records Transfer/Shot Record Fee/Returned Check Fee

Patients who fail to show for any appointment or do not give 24 hrs advance notice of cancellation will have a notation in their chart. You will be charged $50 for each visit you miss or do not give 24 hrs notice of cancellation. There is a $25 charge to transfer medical records to another physician's office, a $5 fee for shot records and non-electronic ADD prescriptions, and a $25 fee for each check returned to our office due to insufficient funds.

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Assignment

I assign the benefits from my insurance carrier to this clinic for the medical/surgical benefits I am entitled to.

Release of Information

I authorize Starside Pediatrics to release to my insurance carrier and its agents any information needed to determine benefits or benefits payable for related services.

I have read and agree to the Financial Policy, Assignments, and Release of Information paragraphs as stated above.

Patient or Responsible Party Signature **Date**

_____

Person Signing on Behalf of Patient (Print Name) **Date**

_____

Phone Number

Financial Policy

Whom may we thank for referring you?_____

Do you have insurance that may cover any part of our professional care? Yes / No If Yes, please present insurance card.

Emergency contact/Name of nearest relative not living with patient _____

Address _____ Phone _____

It is customary to pay for services as they are rendered unless other arrangements have been made in advance. All professional services rendered are charged to the patient. We request you pay by check or credit card at each visit.

I understand that if I do not pay as services are rendered, a service charge may be added each month if there is an outstanding balance. Should this account become delinquent, I understand that I am responsible for any and all legal fees, court costs and collection fees involved as a result of any collection activity.

Patients on PPO's will be responsible for non-covered charges (deductibles, co-pays, etc.) at the time of each office visit. Insurance cards must be presented at each visit in order for our office to file with contracted PPO's.

I authorize the release of any medical or health related information to process my insurance claim. I authorize payment of any insurance benefits to Starside Pediatrics for services rendered when this office files directly to my insurance company.

Signature of Parent or Guardian _____ **Date**_____

Pediatric Health History Form

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Last Name: _____

First Name: _____

DOB: ____ / ____ / ____

Your relationship to Child: _____

Child's previous doctor/primary care provider: _____

Present Health Concerns: _____

_____

_____

Medicines/Vitamins: _____

Herbs/Home Remedies: _____

Allergies/Reactions to Medicines/Vaccinations: _____

_____

Pregnancy & Birth

Where was your child born? _____

Is the child yours by:

☐ Birth ☐ Adoption

☐ Stepchild ☐ Other

Please indicate any medical problems during pregnancy

☐ None ☐ Specify: _____

Delivery by ☐ Vaginal birth ☐ Caesarean If Caesarean, Why? _____

Birth Weight: _____ Birth Length: _____ APGAR Score 1 min. _____ 5 min _____

Please indicate any medical problems during the baby's new born period ☐ None

If premature, how early? _____ Other problems? _____

Last Name: _____

First Name: _____

DOB: ____ / ____ / ____

Nutrition & Feeding

Is/Was your child breast fed? Yes ☐ No ☐

If so, how long? _____

Has your child had any unusual feeding/dietary problems?

☐ No ☐ Yes If yes, please specify:

☐ No ☐ Yes If yes, please specify:

_____

_____

Milk intake now: Type ☐ Cow's milk ☐ Nonfat

☐ 1% Fat ☐ 2% Fat ☐ Whole

☐ Soy Milk ☐ Rice Milk ☐ None/Other

Average ounces per day (Note: 8 oz = 1 cup)

_____

Sleep

Hours per night _____

Naps (Number & Length) _____

Any sleep problems? _____

_____

Development

At what age did your child: Sit alone _____

Walk alone _____ Say words _____

Toilet Train (daytime) _____

Dental History

Has child been seen by a dentist? ☐ No ☐ Yes

If so, how often? _____ Date of last visit _____

Immunizations/Infectious Diseases

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases?

☐ Chickenpox ☐ Measles ☐ Mumps

☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

Exposure/Habits

Any concerns about lead exposure? ☐ No ☐ Yes
(old home/plumbing/peeling paint)

If yes, reason _____

Do any household members smoke? ☐ No ☐ Yes

TV – Hours per day _____

Computers hr/day _____

Video Games hr/day _____

Past Medical History

Please describe any major medical problems and their dates:

_____

_____

_____

Hospitalization/Operations (with dates)

_____

_____

Broken bones or Severe sprains

_____

_____

Family History

Last Name: _____

First Name: _____

DOB: ____ / ____ / ____

Please indicate any deaths of your immediate family members:

_____

Please indicate family members (parent, sibling, grandparent, aunt/uncle with any of the following conditions:

Alcoholism: _____

High Cholesterol: _____

Cancer, specify type: _____

High Blood Pressure: _____

Heart Disease: _____

Stroke: _____

Depression/Suicide: _____

Bleeding or Clotting Disorder: _____

Genetic Disorders: _____

Asthma/COPD: _____

Diabetes: _____

Other: _____

Social History

Who lives at home?

Name	Age	Relationship

Are your child's parents

☐ Married ☐ Unmarried

☐ Divorced

If divorced or separated, when? _____

Parent/Guardian #1's Occupation: _____

Parent/Guardian #1's Employer: _____

Parent/Guardian #2's Occupation: _____

Parent/Guardian #2's Employer: _____

Childcare situation ☐ Parents ☐ Others

Specify who and how often _____

Concerns about your child: ☐ Alcohol Use ☐ Tobacco

☐ Sexual Activity ☐ Aggressive Behavior

Is violence at home a concern? ☐ No ☐ Yes

Are there guns in the home? ☐ No ☐ Yes

School History

Did/does your child attend school or preschool?

☐ No ☐ Yes

Current Grade _____

Name of School _____

Any concerns about school performance?

_____

Any concerns about relationship with:

☐ Teachers ☐ Peers

If more than 4 years old: does your child have a best friend?

☐ No ☐ Yes

Sports/Exercise: Type _____

How often? _____ How Long? _____

Last Name: _____

First Name: _____

DOB: ____ / ____ / ____

Review of Symptoms:

Please check any **CURRENT** problems your child has on the list below:

General
_____Fevers/chills/excessive Sweating
_____ Unexplained weight loss/gain

Eyes
_____ Squinting/"crossed" eyes/ Asymmetric gaze

Ears/Nose/Throat
_____ Unusually loud voice/hard of Hearing
_____ Mouth breathing/snoring Bad breath
_____ Frequent runny nose
_____ Problems with teeth/gums

Cardiovascular
_____ Tires easily with exertion
_____ Shortness of Breath
_____ Fainting

Respiratory
_____ Cough/wheeze
_____ Chest pain

Blood/Lymph
_____ Unexplained lumps
_____ Easy bruising/bleeding

Gastrointestinal
_____ Nausea/vomiting/diarrhea
_____ Constipation
_____ Blood in bowel movement

Genitourinary
_____ Bedwetting
_____ Pain with urination
_____ Discharge: penis/vagina

Musculoskeletal
_____ Muscle/joint pain

Skin
_____ Rashes
_____ Unusual Moles

Allergy
_____ Hay fever/ichy eyes

Neurological
_____ Headaches
_____ Weakness
_____ Clumsiness

Psychiatric/Emotional
_____ Speech problems
_____ Anxiety/stress
_____ Sleep issues
_____ Depression
_____ Nail biting/thumb sucking
_____ Bad temper/breath holding/jealousy

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Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Starside Pediatrics, must have my consent, therefore, I authorize Starside Pediatrics to disclose my PHI as described in the provided forms, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

☐All Procedures☐Test Results☐Appointments☐Other☐Surgeries☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name:_____Relationship:_____

Name:_____Relationship:_____

Contact Information:

I authorize Starside Pediatrics to contact me at the following number with results or questions:

Home_____Cell_____Work_____

May we leave a detailed message on your answering machine or voicemail?Yes☐No☐ Failure to check one of these boxes may delay results.

By Patient: (Print and sign)_____Date:_____

Or Patient's Representative (Print name, sign and describe authority)

_____Date:_____

Authorization expires one year from signature date.

In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

A copy of our Notice of Privacy Practices will be provided at your request.

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Medical Authorization for Minors

Printed Name(s) of Child(ren): _____ Child(ren)'s DOB: _____

_____ _____

_____ _____

_____ _____

We (I) hereby authorize the following persons to authorize **medical treatment** for the above named child:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

We (I) also authorize the following individuals to give consent for and sign for **immunizations** for the above named child:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

We (I) also authorize Starside Pediatrics to copy and/or fax my Child's/children's' shot record(s), health statements, vision/hearing, or any other necessary health documents at my request without a signed authorization.

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____

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Patient Name: DOB:

Due to recent changes in Texas legislation we are required to ask you whether or not you carry secondary insurance coverage. Please be aware that we do not file secondary insurance of any kind. Although we do not file secondary coverage, we are required to keep documentation of any secondary insurance coverage you have for claims filing purposes.

☐ Yes, I have secondary insurance. (Please provide copy of card)

☐ No, I do not have secondary insurance.

Signature Date

Current Address

Phone Number Work

Copy of Secondary Insurance Card:

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We appreciate you selecting Starside Pediatrics for your child's health care. As a provider for your company's health plan, we are committed to quality health care. Services recommended for your child may not be a benefit of your insurance plan. Please be advised that any expense not covered by your plan, such as check-ups, immunizations, and laboratory tests, will be your responsibility and will be billed to you. Our routine schedule of these services follows the recommendations of the American Academy of Pediatrics.

Employers have the option of customizing benefit plans for their employees. All health plans are not alike. Therefore do not assume all services will be a covered benefit. You can get general coverage information about your child's benefit plan by calling the telephone number on your insurance card. We ask you to familiarize yourself with your company's insurance coverage to minimize the possibility of misunderstanding any professional fees not covered by your insurance plan.

This office is not responsible for any dissemination or disclosure of your child's confidential medical information once we provide such information, at your request, to your health insurer, employer or any other third party.

Signature of Parent or Guardian _____ Date _____

Waiver for Procedures/Services Provided by Starside Pediatrics

Starside Pediatrics provides several services to patients that may not be covered by insurance. These services are offered as a convenience for families, but they are not required in order for a child to receive care in the office. Insurance companies vary according to what services they cover and how much they pay for the service. Examples include vision testing and bilirubin testing. Parents always have the right to choose if and where to have the service provided. If a parent wishes to have the service performed elsewhere, the appropriate instructions and lab request or prescription will be given if needed. Parents may also elect to have the service performed in the office, but will need to pay the fee if it is not covered.

After Hours Calls:

For urgent afterhours issues, Starside Pediatrics uses a nurse answering service. Registered pediatric RNs will return any calls within 30 minutes and provide our office with a record of the call. For issues that need additional advice, one of our pediatrician or call partners are always on back up call. You may page the nurse answering service any time after the office closes, on weekends or holidays. There is no charge for calling the nurse triage line; however, a charge of $15 may be incurred if you specifically ask to speak to the on call doctor in addition to the nurse. Patients may leave a voice message in the general office mailbox at any time if they prefer to have the office call them directly during regular business hours.

Vision:

Our office offers the I Spot Vision screen to patients age 6 months and up if there is a concern for vision or as a routine screen at the 12 month and 4 year visit. This is an automated vision screen which is rapid and a highly reliable method of detecting most common treatable sight threatening conditions in children such as nearsightedness, farsightedness, unequal power & astigmatism, lazy eye, strabismus and cataract. Unfortunately, insurance does not fully cover the cost of automated vision screening so if selected, the screen will be done at a charge of $25 cash pay. It will not be billed to insurance so no other fees or deductible will apply. If your child is old enough to cooperate and you prefer the routine eye chart screen, this may be done for no charge at the time of the visit.

ADD Prescription or refills:

Prescriptions for ADD medications are considered non-routine prescriptions. They are typically sent electronically. However, if a paper prescription is required for any reason, then they must be picked up in person, and must be filled within 21 days of the date on the prescription according to law. Because of their non-routine nature, please allow at least 24-48 hours to be sent. If a paper prescription is required there will be a $5.00 charge.

By signing below, you agree to take full financial responsibility for the cost of the indicated medical service or procedure as outlined above.

Child's name _____ DOB _____

Parent's signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Starside Pediatrics

Sara Gondol, M.D/Privacy Officer

Effective Date: 9/23/2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores on a computer in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or

reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification

would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize

this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

B. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices:

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

C. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices at 817-465-5881.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P O Box 13247
Austin, TX 78711-3247

Phone: 1-877-787-8999 (Toll-Free)

Texas Relay: 7-1-1 or 1-800-735-2989 (Toll-Free) For the deaf or hearing impaired

OCRMail@hhs.gov

The complaint form may also be found at: **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pd**