North Texas Women's Healthcare Associates, P.A.

Welcome

Exceptional Care, Every Patient, Every Time

We appreciate the opportunity to provide you the highest in quality medical care. We are committed to building a lasting relationship with you to serve your continuing health care needs.

Name: _____

- ☐ **New OB Patient** ☐ **New Patient**
- ☐ **Returning Patient (> 3 years since last appointment)**

Clinician you are seeing:

- ☐ **Dr. Gagnon** ☐ **Dr. Vaughan** ☐ **Dr. White**
- ☐ **Dr. Kilianski** ☐ **Dr. Welsh** ☐ **NP Laurie**

Please tell us how you learned about us:

- ☐ **Physician Referral- Name** _____
- ☐ **Family or friends – Name (s):** _____
- ☐ **Our website: www.myobg.com**
- ☐ **Insurance website**
- ☐ **Other website: healthgrades.com, etc.** _____
- ☐ **Our staff – Name:** _____
- ☐ **Hospital**
- ☐ **Newspaper/advertisement**
- ☐ **Other:** _____

Please briefly tell us why you chose us. _____

_____

_____

Please give us your zip code. _____

Once again thank you for choosing us! We appreciate you taking the time to give us this information. Our goal is to use your comments to improve our practice. If you have any questions, concerns, please feel free to contact us at (817) 741-2601.

TEXAS HEALTH CARE, P.L.L.C.

P.O. Box 961205
Fort Worth, Texas 76161-1205

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 MM / DD / YY DATE OF BIRTH 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 MM / DD / YY DATE OF BIRTH 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

Texas Health Care, P.L.L.C. (THC), and it's physicians are committed to securing the privacy of your health information. Accordingly, 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 THC has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, 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 THC 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

Texas Health Care

Patient Name: _____ **Date of Birth:** _____

BMI Screening: When your Height and Weight are entered into our Electronic Health Record, your Body Mass Index (BMI) is calculated automatically. If your BMI is considered above or below normal, we are required to give you information pertaining to a healthy lifestyle of diet and/or exercise. Please visit the Center for Disease Control's website for more information. http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Pneumonia Vaccination Status: If you are 65 years of age or older, it is recommended that you get a Pneumococcal vaccination.

Have you had a Pneumonia Vaccination? Yes No N/A Approximate date of your last vaccination? _____

If no, please talk with your Primary Care Physician about getting one. For more information on the Pneumococcal vaccine please feel free to visit the Center for Disease Control's website at http://www.cdc.gov/VACCINes/vpd-vac/pneumo/default.htm

Breast Cancer Screening: If you are a female 40-69 years of age, it is recommended that you get regular screenings for breast cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening tests.

Have you had a mammogram? Yes No N/A Approximate date of your last mammogram? _____

If no, please talk to your Primary Care Physician or Gynecologist about ordering a mammogram. For more information on mammograms please visit the American Cancer Society's website at www.cancer.org

Colorectal Cancer Screening: If you are 50-75 years of age, it is recommended that you get regular screenings for colorectal cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening test(s).

Have you had a colonoscopy? Yes No N/A Approximate date of your last colonoscopy? _____

If no, please talk to your Primary Care Physician about ordering a colonoscopy. For more information on colonoscopies please visit the American Cancer Society's website at www.cancer.org

Tobacco Use: If you are 18 years old or older: Have you *EVER* used any type of tobacco product (including smokeless products)?

Please circle: **Never** **Current** **Former**

If **NEVER**, you are finished.

If **CURRENT** or **FORMER**, please answer the following questions to the best of your abilities:

1. Type of tobacco used: _____
2. How much per day: _____
3. Approximate age started: _____
4. Have you ever tried to stop? _____ If yes, approximate age: _____
5. What method did you use to try to stop (if applicable): _____
6. Approximate age stopped successfully (if applicable): _____

Please visit the Center for Disease Control's website for additional information on Tobacco cessation. http://www.cdc.gov/tobacco

1141 Keller Parkway
Suite A
Keller, Texas 76248

North Texas Women's Healthcare Associates
Member of Texas Health Care, PLLC

817-741-2601
www.myobg.com

1600 West College
Suite 190
Grapevine, Texas 76051

Name _____ Age _____ Date of Birth _____

Email Address _____

What is the reason for your office visit today? _____

_____

Primary Care Dr. _____ Pharmacy _____

PAST MEDICAL HISTORY

	Self	Family		Self	Family
Headaches/Migraines	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Breast Disease	☐	☐
Diabetes Mellitus	☐	☐	Kidney Disease	☐	☐
Heart Disease	☐	☐	Seizure Disorder	☐	☐
Rheumatic Fever	☐	☐	Anemia/Blood Disorder	☐	☐
Lung Disease/ Asthma	☐	☐	Blood Transfusion	☐	☐
Jaundice/Hepatitis/Ulcers	☐	☐	Mental Disorder	☐	☐

Are there any diseases that "run in the family"? ☐ Yes ☐ No If Yes, list below:

_____

Are you currently taking any medications (including over the counter medications)? ☐ Yes ☐ N If Yes, list below:

_____

Are you allergic to any medications, foods, etc? ☐ Yes ☐ No If Yes, list below:

Describe any reactions: _____

_____

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____

OVER →

HOSPITALIZATIONS

Mo/Yr	Reason	Mo/Yr	Reason
1.		4.	
2.		5.	
3.		6.	

MENSTRUAL/SEXUAL HISTORY

Date last menstrual period began _____ Age at 1st menstruation _____

A normal period lasts _____ days. Menstrual periods occur every _____ days.

Menstrual periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ Light ☐ Moderate ☐ Heavy

Do you bleed or spot between periods? ☐ Yes ☐ No

Do you pass clots? ☐ Yes ☐ No

What is your current method of birth control? _____

Do you bleed during or after intercourse? ☐ Yes ☐ No

Is intercourse painful? ☐ Yes ☐ No

Do you have any other problems with intercourse? _____

PREGNANCY HISTORY

Total number of pregnancies _____ Age at 1st pregnancy _____ Number of living children _____

Did you have any of the following during pregnancy?

☐ High blood pressure
☐ Diabetes
☐ Blood clots in legs
☐ Infections in uterus or breast
☐ Infections in urine
☐ Other problems (Describe below)

If Pregnant how many:

Live Births	_____	Tubal/Ectopic Pregnancy	_____
Still Births	_____	Cesarean Section	_____
Miscarriages	_____	Premature Births	_____
Abortions	_____		

Are there any birth defects or special needs in the family? ☐ Yes ☐ No If Yes, list below:

Do you have any questions, problems, or concerns that you would like to discuss with us today? _____

Texas Health Care

Patient Name: _____ **Date of Birth:** _____

Patient Health Questionnaire (PHQ-9):

Use ✔ to indicate your answer

Over the last 2 weeks, how often have you been bothered by any of the following problems?	***Not at all***	***Several days***	***More than half the days***	***Nearly every day***
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such a reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead, or of hurting yourself in someway				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				

TEXAS HEALTH CARE, P.L.L.C.

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____ , with Texas Health Care, P.L.L.C. unless revoked by me in writing.

Social Security # _____

_____ _____

Date *Patient/Legal Representative*

THCOBP12

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

Texas Health Care, P.L.L.C.

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 18yrs or older) Date

_____

Print Name Birthdate

TEXAS HEALTH CARE, P.L.L.C.

ANNUAL EXAM NOTIFICATION

Texas Health Care, P.L.L.C. has verified my insurance coverage and obtained my benefit information. I understand that if my insurnce does not cover my routine annual exam, I am responsible for the charges, which may include lab work.

Please remember that a benefit quote from your insurance company is not a guarantee of payment.

Patient Name Printed	Physician's Name
Patient Signature	Patient's Date of Birth
Date	

THC99P54

Notice of Privacy Practices

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

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

Treatment, Payment, Health Care Operations

We are permitted to use and disclose your medical information to those involved in your treatment. Texas Health Care, PLLC is a multi-specialty practice and when we provide treatment, we may request that all of your physicians share your medical information with us. For example, your care may require both primary care physicians and specialty care physicians. When we provide treatment, we may request information from all of your physicians so that we can appropriately treat you for all other medical conditions, if any.

- If your physician is a primary care physician, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.
- If your physician is a specialist, when we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.
- If your treatment has been ordered by your physician, but is being provided by an ancillary department, such as any therapies, we are permitted to use and disclose your medical information to those involved in your treatment. When we provide treatment, we may request that your physician share your medical information with us. Also, we may provide your physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered

For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Other uses and Disclosures

We will not use or sell your protected health information for marketing or any other purposes without your expressed permission.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations.

- 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:

L. Timothy Knutson, Privacy Officer
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
tknutson@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.