New Patient Registration Form

Today's Date_____

Last Name_____ First Name_____ Date of Birth_____

Nickname_____ ☐Male ☐Female

Parent/Guardian Name_____ DOB_____/_____/_____

Address_____City_____State_____ZIP_____

Home ph_____cell ph_____ work ph_____

Email_____ Employer_____

Parent/Guardian Name_____ DOB_____/_____/_____

Address_____City_____State_____ZIP_____

Home ph_____cell ph_____ work ph_____

Email_____ Employer_____

Who does patient live with? MOTHER FATHER BOTH GUARDIAN

NOTE: If parents are divorced or living separately, please provide copies of custody papers at FIRST visit

Primary Insurance Company _____ID number _____Group Number_____

Insurance phone number _____

Subscriber's name_____ Subscriber's DOB_____/_____/_____

Subscriber's relationship to patient_____

Secondary Insurance Company_____ ID number _____Group Number_____

Insurance phone number _____

Subscriber's name_____ Subscriber's DOB_____/_____/_____

Subscriber's relationship to patient_____

Preferred Pharmacy_____ **Pharmacy phone number**_____

Medicaid Waiver

Continuum Pediatrics will NOT ACCEPT Medicaid of Texas as primary or secondary insurance.

I _____ (patient's guardian) have read, understand, and agree to the above policy by Continuum Pediatrics. I will be responsible for any non-covered services not covered by my health insurance plan(s).

This waiver is valid for all dates of service. All patients must complete & sign this form even if you have no intention of using Medicaid as a form of payment.

_____ _____ _____

Parent/Guardian's Signature Relationship to Patient Date

Consent for Treatment Authorization

Patient Name _____ Date of Birth _____

Parent/Guardian's Printed name _____

I hereby authorize the following person(s) to seek medical care and make decision in relation to advice rendered at Continuum Pediatrics and/or its employees in my absence:

_____	_____	_____	_____
Printed Name	Relationship to Patient	Printed Name	Relationship to Patient
_____	_____	_____	_____
Printed Name	Relationship to Patient	Printed Name	Relationship to Patient

This authorization shall remain in effect from today's date for a period of one year, sooner if revoked in writing or if any changes.

Assignment of Benefits

Financial responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our billing office. Necessary forms will be completed to file for insurance carrier payments.

If the child has multiple carriers it is solely the parent/guardian's responsibility to inform this office. Should any claims be denied of payment for this reason and our office has not been aware, payment of all denied claims will become the responsibility of the parent/guardian.

There may be times when a "well" visit will be changed to a "sick" visit based on diagnosis during your evaluation by the physician. Your insurance company may require you to pay additional coinsurance or fees at the time of service. Please check with your insurance carrier about your specific benefits.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment checks directly to Continuum Pediatrics, a division of Texas Digestive Disease Consultants- GI Alliance, for medical services rendered to myself and or my dependents regardless of my insurance benefits, if any. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE.

Authorization to release information

I hereby authorize Continuum Pediatrics to 1) release any information necessary to insurance carriers regarding my illness and treatments (2) process insurance claims generated in the course of examination and treatments; (3) allow a photocopy of my signature to be used in the process of insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from on behalf of myself and or my dependents, and I understand that by making this request, I BECOME FULLY FINANCIALLY REPONSIBLE FOR ANY AND ALL CHARGES INCURRED IN THE COURSE OF THE TREATMENT AUTHORIZED.

I FURTHER UNDERSTAND THAT FEES ARE DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED, AND I AGREE TO PAY ALL SUCH CHARGES INCURRED IN FULL IMMEDIATELY UPON PRESENTATION OF THE APPROPRIATE STATEMENT. A photocopy of this assignment is to be considered as valid as the original.

_____

Parent/Guardian's Signature

_____ _____

Relationship to Patient Date

Rev 3/18

Office Policies

Vaccine Policy:

_____I have read the enclosed vaccine policy and intend to vaccinate my child according to the most current guidelines set forth by the American Academy of Pediatrics and the US Centers for Disease Control.

After Hour Calls:

_____Our office hours are Monday through Friday 8:00am to 5:00pm. We make every effort to return patient calls promptly, usually by the end of the business day. After hour calls are defined as calls received after 5:00pm Monday-Friday and all weekends or holidays. These calls will accrue a **$35.00** ***after hours call fee*** applied to your account. This fee cannot be billed to your insurance company.

No Show Policy:

_____We ask you to be considerate of the medical needs of others and call our office promptly within 24 hours of your appointment if you are unable to make your appointment time. This allows us to make your appointment available to another patient who needs medical attention.

If you do not arrive for your appointment, or fail to cancel prior to 24 hours before your appointment time, there will be a **$50.00** ***no show fee*** applied to your account that will need to be paid in full by the next scheduled appointment time. This fee cannot be billed to your insurance company.

You may be reminded of your upcoming appointment by portal reminder, text, or phone call. Please understand that these reminders regarding your appointment are a COURTESY only, any disputes regarding no shows because of a courtesy call or text "not received" will NOT be waived. You are ultimately responsible.

The doctors make every effort to be respectful of our patients' time and to see our patients on time. Please be aware that if you arrive **10 minutes** after your scheduled appointment time, you may be asked to reschedule.

Letters/Completion of Forms:

_____Please bring any forms that require a doctor's approval to your appointment. Any requests for forms to be completed after an appointment will accrue a fee. This fee will be applied to your account and will not be covered by insurance. Please give our office 48 hours to complete any forms. Any letter that you request the physician to write also will incur a fee. This fee cannot be billed to your insurance company. Please contact the office staff for a list of fees for commonly requested forms.

Consent for Photography:

_____I hereby consent Continuum Pediatrics to photograph my child and an adult caregiver. The purpose is to document the identity of the patient and caregiver in the medical and billing records for the purpose of clinical care as well as collection of payments.

_____ _____

Patient's Name (PRINT) Date

_____ _____

Parent's Name (PRINT) Parent/Guardian's Signature

Limited Patient Authorization for Disclosure of Protected Health Information **Form 7.31**
Please print all information. Form must be signed and dated each year.

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

Entity Requested to Release Information:
Continuum Pediatrics

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about the above minor patient to the individual(s) listed below.

Who will be authorized to receive information (list the individuals other than parent/guardians):

Individual Name: _____ Relationship to patient:_____

Phone Number: _____

Individual Name: _____ Relationship to patient:_____

Phone Number: _____

Individual Name: _____ Relationship to patient:_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ Office notes
- ☐ Immunization records
- ☐ Lab results
- ☐ Record of HIV and communicable disease testing
- ☐ X-rays
- ☐ Record of mental health or substance abuse treatment
- ☐ Financial history report (previous 3 years only).

☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

-This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
-You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
-The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
-We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Parent/Guardian name(PRINT)_____

Parent/guardian signature _____Date_____

You have the right to receive a copy of signed authorization upon request.

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

New Patient Health History

Name_____ Date of Birth _____

Birth History

Was your child born □ full term □ early

What was your child's weight at birth? _____Any problems after birth? _____

Was your child delivered □ by C-section □ vaginally

Does your child have any chronic medical problems?

_____

Does your child take any medications on a regular basis? If so, please list below.

_____

Does your child have any allergies to medications?

_____

Has your child ever been hospitalized overnight? (not ER visits)

_____

Has your child ever had any surgeries? If so, please list below.

_____

Tell us about your family:
Patient's Mother: age _____ medical problems _____
Patient's Father: age _____ medical problems _____
Patient's Brother(s): age _____ medical problems _____
Patient's Sister(s): age _____ medical problems _____

Do you have any forms that you would like the doctor to complete? _____YES _____NO

Do you have any concerns you would like to discuss with the doctor today?

_____

Informed Consent for Telemedicine Medical Services

1. Introduction: Please read this document thoroughly and completely. To better serve the needs of the community, especially in light of the Coronavirus pandemic, health care services are now available using telecommunications or information technology ("Telemedicine"). Telemedicine involves the use of real-time evaluation, diagnosis, consultation, and treatment of health conditions using interactive telecommunications technology allowing the health care provider to see and communicate with you in real-time.
2. Consent for Treatment: You have voluntarily requested that a health care provider of GI Alliance participate in your medical care through the use of Telemedicine. In doing so, you understand, acknowledge and agree to the following:
   a. The health care provider may practice in a location different than where you normally go to receive in-person medical care.
   b. Unlike traditional medicine, the health care provider providing the Telemedicine services will not have the opportunity to meet with you face to face.
   c. The health care provider providing the Telemedicine services must rely on the information you provide.
   d. To the best of your ability, you agree to provide complete and accurate information concerning your medical history, condition and care as may be requested by the health care provider.
   e. You understand that if the health care provider feels that your medical needs cannot be adequately addressed using Telemedicine, you may be required to seek an in-person evaluation.
   f. You understand you can stop your Telemedicine session at any time.
   g. You understand you can ask questions or seek clarifications of the Telemedicine procedures and technology at any time.
   h. You understand that no guarantee of any specific result or cure is made by the health care provider rendering the Telemedicine services.
   i. If you experience an emergency after the Telemedicine session, you should alert your primary treating physician and dial 911 or go to the nearest emergency department.
3. Risks. You agree and acknowledge that there are potential risks associated with receiving medical care using Telemedicine:
   a. The Telemedicine session may be interrupted or disconnected due to a technological problem or equipment failure.
   b. There may be electronic tampering.
   c. The advice provided by the health care provider may be based on factors not within his/her control, such as incomplete or inaccurate information provided by you or distortions of diagnostic images or specimens due to their electronic transmission.
4. NOTICE CONCERNING COMPLAINTS. While we hope all patients are happy with the Telemedicine services they receive, you have a right to make a verbal or written complaint. If you have comments, questions or concerns, please contact us. Telemedicine Consent Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation to the following address:

   Texas Medical Board
   Attn: Investigations
   333 Guadalupe, Tower 3, Suite 610
   P.O. Box 2018, MC-263
   Austin, TX 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information on filing a complaint with the Texas Medical Board, visit the Texas Medical Board website at www.tmb.tx.us

Patient or Guardian Signature: _____

Name (printed): _____ Date: _____

Medical Record Release

To whom it may concern:
I hereby authorize the release of my child(ren)'s medical records, or copies of such, and request that they be transferred from your office to **Continuum Pediatrics**, as soon as possible.

From:

Office Name _____

Address _____

City _____ State_____ ZIP_____

Phone _____ Fax _____

To: Kathryn K. Mandal, MD, FAAP
Krystyna Wesp, DO, FAAP
Likhitha Reddy, MD
Cynthia Giovannetti, MD

Continuum Pediatrics

9509 N. Beach St, Suite 102
Fort Worth, TX 76244
ph. 817.617.8600
fax 1.877.906.1852
email: frontdesk@continuumtx.com

NO DISKS/CD's PLEASE!!

Check the records to be disclosed:

☐ Immunizations ☐ Growth Charts Other: _____

Below are my child(ren)'s names and date(s) of birth:

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

I understand that these records may contain details regarding psychiatric illness, drug or alcohol treatment, HIV/AIDS testing and status, sexually transmitted disease diagnosis and other sensitive medical information of either my children, myself, or my child's other parent.

Parent's name_____ Relationship to patient_____

Parent's Signature_____ Date_____

Contact phone number _____

continuum
PEDIATRICS

Thanks for coming! How did you hear about us?

☐Former, Current, or sibling's patient of office

☐Facebook post

☐Internet search

☐Heard about her from a friend _____

☐Postcard mailed to your home

☐Another doctor referred you _____

☐Attended a community event _____

☐Other _____

Vaccine Policy

◆ We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

◆ We firmly believe in the safety of our vaccines.

◆ We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

◆ We firmly believe, based on all available literature, evidence, and current studies, that vaccines DO NOT cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

◆ We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox . . . I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even dis- cussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many people in Europe chose not to vaccinate their children. As a result of under immunization, there were large outbreaks of measles, with several deaths from complications of the disease. In 2010 there were more than 3000 cases of whooping cough in California, with nine deaths in children less than six months of age. Again, many of those who contracted the illness (and then passed it on to the infants, who were too young to have been fully vaccinated) had made a conscious decision not to vaccinate.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with our office in advance of your visit. **Please be advised, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Continuum Pediatrics.**

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine and booster doses of Tdap and varicella vaccines by age 12 years.

Finally, if you should absolutely refuse to vaccinate according to the CDC and AAP guidelines, despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

From Drs. Kathryn Mandal, Krystyna Wesp, Likhitha Reddy, Cynthia Giovannetti, and the Staff of Continuum Pediatrics.

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.

Protected Health Information (PHI) about you is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. Our practice must maintain the privacy of PHI under a federal law known as the Health Insurance Portability and Accountability Act (hereafter "HIPAA") and requirements called the "Privacy Rule." Certain types of health information, such as regarding HIV, AIDS, mental health, substance abuse and genetic information, may also have additional protections under applicable state law. Under HIPAA and the Privacy Rule, our practice must provide you with this Notice of its legal duties and privacy practices with respect to PHI and must follow the terms of the Notice that is currently in effect. This Notice explains how our practice provides that protection. This Notice applies to The GI Alliance and its HIPAA-covered subsidiaries and affiliates which are under common control and/or common ownership, designated for HIPAA purposes as an affiliated covered entity.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We will provide you with a paper copy of our current Notice if you call our office and request that a copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and on the GI Alliance website at : https://gialliance.com/patient-portal/noticeofprivacypractices. We reserve the right to change the terms of the Notice and to make the new Notice provisions effective for all PHI that we maintain. A revised Notice will be available at the practice and on the GI Alliance website.

You have the right to authorize other use and disclosure - This means your PHI will not be disclosed to anyone without your express written authorization, except as indicated in the section below titled How We May Use or Disclose PHI Without your Authorization or Consent. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or for a sale of PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or our practice has already taken action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. Your request must be in writing, signed by you or your personal representative, and must inform us how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies. In certain cases, we may deny your request, and you may have the right to appeal that decision. If we approve your request, we are required to provide you with

access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - You may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations, or with certain persons involved in your care (such as members of your family, other relatives or close personal friends). If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We must agree to this specific requested restriction for payment or healthcare operations purposes, unless disclosure is otherwise required by law. You have the right to request termination of an existing restriction.

You have the right to request an amendment to your PHI* - You may submit a written request to amend your PHI for as long as we maintain this information. Your written request must be signed by you or your personal representative and must state the reasons for the amendment/correction request. In certain cases, we may deny your request.

You have the right to request an accounting of disclosures* - You may submit a written request, signed by you or your personal representative, for a listing of certain disclosures made by us of your PHI. We will not charge a fee for the first accounting provided in a 12-month period; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a Breach of your Unsecured PHI, as defined by HIPAA, and determines through a risk assessment that notification is required by law.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please contact our Privacy Officer. Contact information is provided at the end of this Notice.

How We May Use or Disclose PHI Without your Authorization or Consent

As permitted by HIPAA, our practice can use or disclose your PHI, without your written consent or authorization, for the purposes listed below. We have provided a description and example below, but this list is not exhaustive; not every particular use or disclosure in every category will be listed.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other healthcare providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose your PHI, as needed, in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, training, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, provide information that describes or recommends treatment alternatives regarding your care, or provide information about health-related benefits, products and services that may be of interest to you. We may contact you regarding fundraising, but you have the right to opt out of

receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may use a health information organization, or other such organization, to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative** or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., unconscious or in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed. **A personal representative is a person permitted by law to make health care decisions on your behalf, such as someone who has a court order to do so or who has signed a valid power of attorney that includes the right to make health care decisions.

Other Permitted and Required Uses and Disclosures – We may disclose your PHI without your written consent or authorization when required by law or as otherwise permitted under HIPAA. Some examples of such disclosures include, but are not limited to: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas/discovery requests that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, veterans, inmates, correctional institutions, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; to assist in disaster relief efforts; to Business Associates; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Incidental Disclosures - Subject to applicable law, we may make incidental uses and disclosures of PHI; these are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services, if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, amendment of your PHI, or to obtain an accounting of disclosures) by notifying our Privacy Officer in writing at Facsimile: 682-477-4367 OR 550 Reserve Street, Suite 550, Southlake, TX 76092:

Effective Date: 10/29/2019