FAMILY HEALTH CENTER
OF BASTROP
BE WELL

Laurier A. Vocal, M.D.
EC.C.FP., F.A.A.RP.
Family Medicine

Pompeyo C. Chavez, M.D.
.Family Medicine

Juan Carlos Ortega, M.D
Family Medicine

Estela Mota, M.D.
Family Medicine

Ronald L. Cox, .M.D.
Allergy & Immunology

Brian L. Sullivan, M.D.
Orthopedics

Clyde Smith, M.D., F.A.C.S
General Surgery

Olivia Y. Blankenship, EN.P.
Family Medicine

T. Michael Fields, PA-C.
Family Medicine

Stephanie Jasik, PA-C.

Johnny L. Bums, F.A.C.H.E.
Administrator

We at the Family Health Center Of Bastrop would like to welcome you to our practice. Thank you for choosing us as your new Primary Care Provider. We look forward to meeting with you on your visit.

It is our goal to deliver high quality medical care in a friendly warm environment. If ever you feel that you have experienced unsatisfactory service from our clinic, please let us know as soon as possible.

Keeping you as healthy as possible is our mission. We look forward to serving you. May you be blessed with health, happiness and harmony in your life. Thanks again for allowing us to tend to your health care needs.

Laurier A. Vocal, M.D.
Medical Director

Pompeyo C. Chavez, M.D.

Hwy 71 E., Suite 101, Bastrop, Texas 78602
(512) 304-0300 Fax (512) 304-0341
www.fhcob.com

FAMILY HEALTH CENTER OF BASTROP

3101 Hwy. 71 East, Suite 101 • Bastrop, Texas 78602
(512) 304-0300 • Fax: (512) 304-0341

PATIENT INFORMATION:

Last Name: ______________________________________ First: _______________________ Middle: _____________
Date of Birth: _________________________ Alias or Nickname: ____
Social Security # ___________-_________-____________ Sex: F M Marital Status: ________________
Mailing Address: _________________________________ City: _______________________ Zip: ________________
Home #: (______) ________________ Cell #: (______) ___________________ Work # (______) __________________
Employer Name: ___________________________ Address: _____________________________ City: _____________
Drivers License: __________________________________ State Issued: ____________________________________

PARENT OR RESPONSIBLE PARTY OF PATIENT:

Name: __________________________________ Address: ____
Phone #: ____ Relation to Patient: __________________________________
Date of Birth: ____________________________ Social Security #: ______________-____________-_______________

PRIMARY INSURANCE COMPANY: ____

Address: ____ Name of Insured: __________________________________
Social Security # ___________-_________-____________ Date of Birth: _____________________________________
Policy ID#: _________________________ Group #: _________________ Relationship to Patient: _________________

SECONDARY INSURANCE COMPANY: ____

Address: ____ Name of Insured: __________________________________
Policy ID#: _________________________ Group #: _________________ Relationship to Patient: _________________

EMERGENCY CONTACT PERSON (PERSON NOT LISTED ABOVE • FAMILY MEMBER OR FRIEND):

Name: _____________________________________ Home #: (______) ________________ Relation: ______________
Address: ___________________________________ City: ________________________ State/Zip: ________________
Employer Name: ______________________________ City: ____________________ Work #: ______________________

ASSIGNMENT OF I NSURANCE BENEFITS

Unless arrangements for insurance are made in advance, payment is expected when services are rendered. When arrangements for insurance are made, I hereby authorize direct payment of surgical/medical benefits to Family Health Center of Bastrop for services rendered. I understand that I am financially responsible for any balance not covered or denied for patient negligence by my insurance policy.

AUTHORIZATION TO RELEASE PATIENT I NFORMATION

I hereby authorize the release of any medical or incidental information that may be necessary for either medical care or in process applications for financial benefit.

MEDICARE AND MEDICAID BENEFITS

I give my permission to have my Medicare/Medicaid claims filed on my behalf and authorize release of all records and information necessary to process such claims. I am aware that FHCOB does not accept Medicare on Assignments as 100% coverage. I further request that payment be made to the physician on assigned claims.

AUTHORI ZATION TO TREAT

I hereby authorize treatment by Family Health Center of Bastrop. PLLC

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL.

Patient Signature: ____ Date Signed: ___________________________________

Parent / Guardian Printed Name: _____________________________ Signature: _______________________________________

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PHYSICIAN ASSISTANT CONSENT

This facility has on staff a Physician Assistant to assist in the delivery of medical (may indicate specialty) care.

A Physician Assistant is not a doctor. A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a Physician Assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Physician Assistant may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic producers
- Formulating a working diagnosis
- Developing and implement a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the Physician Assistant and request to see a physician.

Name ______________________ Date ______________________

Signature ______________________ Witness (optional) ______________________

NURSE PRACTITIONER CONSENT

This facility has on staff a Nurse Practitioner to assist in the delivery of medical (may indicate specialty) care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner is a Registered Nurse who has received advance education and training in the provision of health care. A Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provided health maintenance care. In addition, the Nurse Practitioner may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of a Nurse Practitioner for my health care needs.

I understand that at any time I can refuse the see to Nurse Practitioner and request to see a physician.

Name ______________________ Date ______________________

Signature ______________________ Witness (optional) ______________________

GD Rev 04/15

PATIENT FINANCIAL RESPONSIBILITY POLICY

1. **General.**

a. The patient's insurance policy is a contract between the patient and his or her insurance company. However, all charges regardless of the insurance coverage are the patient's responsibility and the patient is ultimately responsible for unpaid balances. As a courtesy to our patients, FHCOB bills the patients' insurance and make every effort to ensure that claims are promptly and correctly processed. FHCOB also bills patients' secondary insurance when patients provide complete insurance information.

b. Patient co-pays, deductibles, and co-insurance amounts are expected at the time of service, and any remaining payment is due in full within 30 days of receiving the first statement from FHCOB. We accept cash, checks, money orders, debit cards and credit cards.

c. If you cannot pay your balance within 30 days, please contact our billing department at (512) 321-8888 or (512) 321- 8899 for assistance. There are several ways you can pay your bill, including possible payment plans, and a Billing Office representative will help find the right one for your financial needs. We may also be able to work with you to see' if you qualify for financial assistance.

2. **Past Due Balances.** A past due balance is any amount owed after the insurance company has paid its portion, but where FHCOB has not received the full patient balance within ninety (90) days from receipt of the first statement. Balances on accounts where a payment plan has been established are **NOT** considered past due balances.

3. **Payment Plans.** Payment arrangements may be made on patients' accounts based on a review of the circumstances and approval by the FHCOB Billing Office. We generally do not extend payment plans to patients who have failed to make timely payments in the past.

4. **Waiver of Co-Pays and Deductibles.**

a. It is the policy of this practice to bill all applicable out of pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures, as well as in accordance with our insurance contracts. FHCOB will not waive co-pay, coinsurance, or deductible amounts for insured patients, except in the limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be *rare.*

b. If FHCOB does waive co-payments or deductibles for a patient based on the patient's financial status, we will maintain record of the information upon which we based this decision. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. FHCOB. Will maintain records of what collection efforts have been made for fees waived in these circumstances.

c. Under no circumstances will our practice engage in any of the following practices with respect to the waiver or lowering of coinsurance and/ or deductibles:

i. Waive or lower coinsurance and deductibles that do not meet the requirements outlined in our Policy.

ii. Advertise, or in any way communicate to the general public that payments from private insurance, Medicare or Medicaid will be accepted as payment in full for health care services provider by our practice, or advertise or otherwise communicate to our patients or to the general public that patients will incur no out of pocket expenses.

iii. *Routinely* approve financial hardship forms which state that the patient is unable to pay co-pay, coinsurance or deductible amounts.
iv. Charge Medicare beneficiaries or private insurance beneficiary's different amounts than those charged to other persons for similar services.
v. Fail to collect co-insurance and deductibles from a specific group of patients for reasons unrelated to indigence or managed care contracting (e.g., to obtain referrals or to induce patients to seek care in my practice vs. another provider's practice who does not waive co-pays and/ or deductibles).
vi. Accept "insurance only" as payment in full for services rendered
vii. Fail to make reasonable collection efforts to collect a patient's balance.

5. **Wellness Examinations.** Patients must be aware that if they are scheduled for a wellness examination that is covered at 100% of allowable (no patient liability expected), they **MAY BE** billed if the visit falls outside of the scope of a wellness examination. (e.g., if you discuss ongoing medical concerns and receive care, whether or not prescriptions
are issued, during the well visit).

6. **Financial Hardship Determinations.**
a. For indigent, uninsured, or underinsured patients, FHCOB may reduce or eliminate the patient's financial responsibility for medically necessary and appropriate treatment on a case-by-case basis where the patient qualifies under our financial hardship guidelines.

b. Financial hardship determinations are based upon review of household income, assets, and liabilities in relation to current Federal Poverty Income Guidelines. As part of the process, we generally evaluate income levels, net worth, employment status, other financial obligations, the amount of frequency of healthcare bills, and other circumstances. ***INSURED PATIENTS WHO CHOOSE NOT TO HAVE THEIR. CLAIM FILED WITH THEIR INSURANCE COMPANYARE NOT ELIGIBLE FOR OUR FINANCIAL HARDSHIP ASSISTANCE PROGRAM.***

c. The determination of financial hardship is applicable to the current episode of care. To waive or reduce future payments, the patient must again provider financial hardship. The patient and the Billing Office representative shall sign a statement detailing that the practice has reviewed proof of financial hardship, and what bills are being reduced or waived.

7. **Applying for Financial Hardship Assistance**
a. The patient or responsible party must complete a Patient Financial Hardship Application, and sign the form.

b. Submit the completed worksheet and any supporting documentation (e.g., W-2's, Federal tax return, pay stubs, etc.) to our Billing Office for review.

c. We will review your application upon receipt and contact you if additional information is required. Applications that are incomplete or missing supporting documentation will not be reviewed.

d. We will contact you regarding your application, generally within 5 business days after we receive your complete application and all required documentation. The representative will inform you of our decision regarding your request for financial assistance and, if applicable, the level of discount for your outstanding FHCOB bill.

I, ___________________________, have received a copy of the Family Health Center of Bastrop Patient Financial Responsibility Policy. I understand that it is my responsibility to ensure I have read and abide by this policy.

____

Patient/Guarantor Signature

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ACKNOWLEDGEMENT

I have reviewed the 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 Date

____

Printed name of patient (or representative)

I give my permission to be notified by an automated system to alert me of my appointments.

I DO NOT give my permission to be notified by an automated system to alert me of my appointments.

_______________________________ _______________________

Signature Date

1) Has your insurance, Medicare or Medicaid changed since your last visit at our clinic? YES NO

2) Is today's visit the result of an accident or injury? YES NO

3) Will today's visit result in a workman’s compensation claim being filed? YES NO

ADULT PATIENT HISTORY AND HEALTH ASSESMENT
(PLEASE TYPE CAPITAL LETTERS)

Date ___________ Patient Name/ID#____ M F DOB ______________

FAMILY HISTORY: ***Indicate if any of your blood relatives have or have had any of the following.***

ILLNESS	RELATION	ILLNESS	RELATION
AIDS or HIV		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Bleeding disorder		Lung disease	
Bowel disease		Psychiatric care	
Cancer		Stroke	
Chemical deficiency		Thyroid problems	
Depression		Tuberculosis	
Diabetes		Other (please list):	
Epilepsy / Convulsions			
Glaucoma, eye disease			

SOCIAL HABITS: ***Have you ever used any of the following?***

(check one)				For how long?	When stopped?
Alcohol	Yes	No	Drinks per week?		
Caffeine	Yes	No	Ounces per day?		
Tobacco	Yes	No	Packs per day?		
Street drugs Type:	Yes	No	Frequency?		

Are you sexually active? Yes No How many sexual partners have you had in the last past year? ____________________

Do you exercise safe sex precautions? Yes No

Would you like information on safe sex precautions today? Yes No

PREVENTIVE CARE: Please indicate the last time you had the following. (MM/DD/YY if known)

EXAM / VACCINE	DATE	EXAM / VACCINE	DATE
Cholesterol screening		Flu shot	
Lipid profile		Pneumonia vaccine	
Eye exam: Pupils dilated? Yes No Results:		Sigmoidoscopy Stool occult blood test	
Hearing test		Tuberculosis (TB) skin test	
Hepatitis vaccine		Tetanus / Diphtheria booster	

***Describe any abnormal results*:** ____

____

Female patients only:	DATE (MM/DD/YY)	RESULTS	PERFORMED BY:
Pap Smear			
Clinical breast exam			
Mammogram			

Menstrual history: age onset ________ Regular Irregular Pain / cramps with menstrual flow
Date of last menstrual period: ____________________
Current birth control method: ____________________ Number of pregnancies _______ Number of births ____________
Complications: ____
Do you perform self-breast exams each month? Yes No

Male patient only:	DATE (MM/DD/YY)	RESULTS	PERFORMED BY:
Prostate exam			
PSA (prostate specific antigen)			

Do you perform self-testicle exams each month? Yes No

ADULT PATIENT HISTORY AND HEALTH ASSESMENT

(PLEASE TYPE CAPITAL LETTERS)

Date ___________ Patient Name/ID#____ M F DOB _____________

Are you allergic to any medications? **Yes No** ***If yes, please list.***

Medication:	Reaction:

Please list medications you are currently taking. (Include over-the-counter)

Current medications:	Dosage	Frequency	Reason why:

Indicate if you have or have had any of the following by entering the approximate date of diagnosis; month and year. (If date of diagnosis is unknown, please indicate the approximate age on set).

Illness	Date (MM/YY if known)	Illness	Date (MM/YY if known)
AIDS or HIV		Hepatitis, type:	
Anemia		High blood pressure	
Alcoholism		High cholesterol	
Allergies (other than medications)		Kidney disease	
Anorexia / Bulimia		Liver disease	
Appendicitis		Lung disease	
Arthritis		Measles	
Asthma		Migraine headache	
Cancer		Mononucleosis	
Chemical dependency		Mumps	
Chickenpox		Pneumonia	
Depression		Psychiatric care	
Diabetes		Rheumatic fever	
Emphysema		Rubella	
Epilepsy / convulsions		Sexually transmitted disease	
Frequent kidney or bladder infection		Stomach ulcer	
Frequent lung infection		Stroke	
Gallbladder disease		Thyroid problems	
Gout		Tonsillitis	
Glaucoma, eye disease		Tuberculosis	
Heart disease		Whooping cough	

Enter full date (MM/DD/YY) if known.

Operations:	Date	Other hospitalizations:	Date

Other significant illnesses or injuries: *(Please list)*	Date

CONTROLLED SUBSTANCE POLICY

Policy Statement

At Family Health Center of Bastrop we are always guarding patient safety and for this reason and to be in compliance with the Department of Public Safety Guidelines we have issued this policy that will regulate the prescription protocol of controlled substances.

Scope

This policy applies to all patients of Family Health Center of Bastrop, whether it is a new start on medication or whether the patient is already on long term medication.

Definitions

- The definition of controlled substances for purposes of this policy applies to all Schedule II, III, IV medications as determined by the Controlled Substances Act (CSA).

- The policy need not be applied to prescriptions written for less than two weeks at a time, renewable only once (total of 28 days) for treatment of acute pain and other symptoms.

- For prescriptions beyond a total of 28 days, it is recommended that the medical record documentation include:

    - Patients New to FHCOB: Our physicians will not consider prescription of a controlled substance without first viewing past medical records that detail a patient's diagnosis, previous evaluation, and treatment history. All patients are objectively evaluated, and we attempt to create a care plan that does not involve controlled substances; if controlled substances are required (and the patient is not involved in Hospice or cancer care), the patient will most likely be referred to a pain management practice or other appropriate specialist.
    - For already established patients on a controlled substance they will need to be seen at least every 3 months for the specific condition that requires the use of such controlled substance to be treated.
    - When the determination is made to start a patient on a long term regimen with a controlled substance the patient must undergo a urine drug screen amongst any other lab work or testing that the physician may deem appropriate. Refusing to undergo a UDS will preclude initiation of therapy.
    - Patients understand that they may be required to undergo urine/blood drug screening at any of the follow-up visits for renewal of a controlled substance. Refusal to such test will lead to denial of the prescription. If patient refuses

two times consecutively patient will not be candidate for chronic controlled medications at this practice.

- Patient understands that a positive UDS (urine drug screen) or Blood Drug Screen to unexpected substances will result in a denial of the controlled prescription and will not be candidate for chronic controlled medications at this practice.
- If patient fills, refills or acquires any controlled substances governed by this policy from another healthcare provider without notifying this office will be automatically deemed not candidate for chronic controlled medication prescription from this practice.
- If a patient exhibits the need for chronic pain medication that falls within schedule III (i.e. needs a triplicate prescription) he/she will need to be referred to a pain management specialist for further assessment and treatment. This office will not prescribe pain medication of that level for chronic use unless patient is under end-of-life care or a cancer patient.
- If the prescription or controlled substance supply is lost it will not be refilled until next refill date. If the medication or prescription was stolen it will only be refilled after a filed police report has been presented to the office.
- If patient takes medication beyond the precise directions or runs out of medication earlier, will constitute a violation of this policy and will be automatically deemed not candidate for chronic controlled medication prescription from this practice.
- Controlled substances will not be refilled for more than a months supply at a time.
- Refills for these medications will need a face-to-face encounter every 3 months. For those periods in between, patients will need to call for a refill 48hrs in advance.

By signing below, I acknowledge that I understand the implications of this policy and will abide by it.

________________________	________________________
Patients Name	Patients Date Of Birth
________________________	________________________
Signature	Guardian Name
________________________	
Date	

PATIENT PORTAL AUTHORIZATION

Laurier A. Vocal, M.D.
EC.C.FP., F.A.A.RP.
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Stephanie Jasik, PA-C.

Johnny L. Bums, F.A.C.H.E.
Administrator

Our patient portal lets established patients communicate more easily with us. The portal is not intended for "Internet Doctor Visits" or new problems. Instead, it will make regular communion more flexble.

You can:

- Request refills and schedule appointments.
- Update your contact and insurance information.
- Check your medication list, medical history and your visits.
- Get your lab results quickly.
- E-mail us securely back and forth.

We want your records to be complete and correct. Let us know if there's any problem with your records. Sometimes we may use medical jargon in your records and it can lead to confusion. If something doesn't make sense, let us know.

Privacy matters. We will never sell/trade/abuse your e-mail address. The patient portal is protected just like phone calls are. Use our Privacy Form to tell us who it's OK to share with. We also think it's important for you to protect privacy on your end.

We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We track security laws like HIPAA and HITECH. We protect and maintain all of the data at our clinic.

Bedside manner is complicated via e-mail. It's easy to misread 'information or emotion. We'll try to keep things brief and clear on the Portal We really appreciate your help on that, too. If a message takes a long time to write, it's probably better done in person.

If we have trouble, abuse or "Spam", we may need to change policies, suspend accounts, or even terminate the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues. If there's an emergency, you should go to Urgent Care, the Emergency Room or call 911.

I understand there are pros and cons to using the patient portal for communications with the clinic and I desire to voluntarily participate and furnish the attached information:

PATIENT NAME (PRINT): ______________________________

DATE OF BIRTH: ______________________________

E-MAIL ADDRESS: ______________________________

PATIENT'S SIGNATURE: ______________________________

3101 Hwy 71 E., Suite 101, Bastrop, Texas 78602
(512) 304-0300 Fax (512) 304-0341
www.fhcob.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of information from the medical records of:

Patient Name:______________________________ Date of Birth: _____________

SSN #: ________________________________ Phone: (______)__________________

INFORMATION RELEASE TO:
Family Health Center of Bastrop
3101Hwy 71 East, Suite 101
Bastrop, TX 78602
Phone (512) 304-0300
Fax (512) 304-0341
STAT Fax (512) 308-1034
__ Larry Vocal, M.D.
__ Pompeyo Chavez, M.D.
__ Juan Carlos Ortega, M.D.
__ Estela Mota, M.D.

INFORMATION RELEASE FROM:
____
____
____
____
Phone:________________________
Fax: _________________________

Please release the following:
__ Problem List
__ Progress Notes
__ History/Physical Exam
__ EKG Reports
__ Immunizations
__ X-Ray reports
__ Lab Reports
__ ALL RECORDS

Including information (if applicable) pertaining to:

__ Mental Health _ Drug/Alcohol __ HIV/ AIDS __ Communicable Dz.

I understand that the information released is for the specific purposes signed above. Any other use of this information without the specific consent of the patient is prohibited, I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire ninety (90) days after the date of my signature unless otherwise specified.

________________________________ ____________________
Signature of Patient or Legal Representative Date

________________________________ ____________________
Relationship to Patient Witness

RELEASE OF PROTECTED HEALTH INFORMATION

______________________________ ______________________________
Patients Name Patients Date Of Birth

I grant permission for my healthcare provider and their representatives of Family Health Center Of Bastrop to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account with my family or friends.

Are there any specific people you would like the staff at Family Health Center Of Bastrop to disclose medical/appointment information to?

WE WILL NOT TALK TO ANYONE THAT IS NOT ON THIS FORM, INCLUDING YOUR SPOUSE, PARENT OR CHILDREN.

Release my protected information to the following person(s)/ entity:

Name___________________Phone_________________Relationship______________

Name___________________Phone_________________Relationship______________

Name___________________Phone_________________Relationship______________

The information you may release subject to this authorization is the following:

Appointment date/time Yes No
Explanation of diagnosis and/ or procedure Yes No
Lab reports Yes No
Billing information Yes No

It is OK to leave a message on my voicemail when reporting normal results Yes No

I DO NOT WANT ANY INFORMATION SHARED WITH FAMILY OR FRIENDS

______________________________ ______________________________
Signature Guardian Name

____
Date

Family Health Center of Bastrop

NOTICE OF PRIVACY PRACTICES

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

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for your health care.
As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures:
We use and disclose health information for purposes of treatment, payment and health care operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or others involved in providing treatment to you.
- **Payment:** We may use and disclose your heath information to obtain payment for services we provide to you.
- **Health Care Operations:** We are permitted to use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation certification, licensing or credentialing activities.

Disclosures and Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your heath information or to disclose it to anyone for any purpose. If you give an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. We will not use your health information for marketing communications without your written authorization.
To your family and friends: We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify or to assist in notifying of (including identifying or locating) a family member, your personal representative or another person responsible for your care your location your general condition or death. If you are present than prior to use or disclosure of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing ony health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Legal Requirements: We may use or disclose your health information when we are required to do so by law.

Your Rights:
1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:

- Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record.
- Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- Protected health information involving laboratory tests when your access is required by law.
- If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you.

- If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research.
- Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law.
- If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

We may also deny a request for access to protected health information if:
- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person.
- The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
- The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:
   - Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment.
   - Is not part of your medical or billing records.
   - Is not available for inspection as set forth above.
   - Is not accurate and complete.

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:
   - To carry out treatment, payment and health care operations as provided above.
   - To persons involved in your care or for other notification purposes as provided by law.
   - For national security or intelligence purposes as provided by law.
   - To correctional institutions or law enforcement officials as provided by law.
   - That occurred prior to April 14, 2003.
   - That are otherwise not required by law to be included in the accounting.
6. You have the right to request and receive a paper copy of this notice from us.
7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

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Printed Name Initials

Contact Officer: Johnny Burns **Telephone:** 512-304-0300 **Fax:** 304-0341 **Address:** 3101 HWY 71E, Suite 101. Bastrop, TX 78602