Pinewood MEDICAL CLINIC, P.A.

PATIENT NAME: _____ DOB: _____

PINEWOOD MEDICAL CLINIC, P.A.

PATIENT HEALTH HISTORY AND ASSESSMENT

NAME:	**DOB:** / /
SEX: MALE ○ FEMALE ○	**LAST PHYSICAL EXAM:**

PAST MEDICAL HISTORY: PLEASE CHECK THE BOX AND LIST THE YEAR OF ANY OF THE FOLLOWING CONDITIONS THAT YOU EITHER HAVE NOW OR HAVE BEEN DIAGNOSED WITH IN THE PAST:

- ☐ AIDS/HIV
- ☐ ABUSE
- ☐ ABNORMAL PAPSMEAR
- ☐ ALCOHOLISM / DRUGS
- ☐ ANEMIA
- ☐ ANXIETY/NERVES
- ☐ ALLERGIES
- ☐ ANOREXIA/BULIMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ALLERGIES
- ☐ BLEEDING DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ BLOOD CLOTS
- ☐ CANCER: (SPECIFY)
- ☐ CHRONIC PAIN
- ☐ DEPRESSION
- ☐ DIABETES / SUGAR
- ☐ EMPHYSEMA
- ☐ EPILEPSY / SEIZURES
- ☐ GALLBLADDER DISEASE
- ☐ GAS, INDIGESTION, REFLUX
- ☐ GLAUCOMA/CATARACTS
- ☐ GOUT
- ☐ HEADACHES / MIGRAINE
- ☐ HEART DISEASE
- ☐ HEPATITIS: ○ A ○ B ○ C
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ INTESTINAL DISEASE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ MEASLES
- ☐ MONONUCLEOSIS
- ☐ MUMPS
- ☐ OSTEOPOROSIS
- ☐ PNEUMONIA
- ☐ PROSTATE PROBLEMS
- ☐ PSYCHIATRIC / MENTAL PROBLEMS
- ☐ RHEUMATOID ARTHRITIS
- ☐ SERIOUS ACCIDENT/INJURY
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ STROKE
- ☐ THYROID DISEASE: ○ HIGH ○ LOW
- ☐ TUBERCULOSIS
- ☐ ULCERS / STOMACH

OTHER: _____

PAST SURGICAL HISTORY LIST *THE YEAR* YOU HAD ANY OF THE FOLLOWING.

☐ NO SURGICAL HISTORY TO REPORT.

SURGERY	YEAR

HOSPITALIZATIONS / MAJOR TRAUMA LIST ANY HOSPITALIZATIONS.

☐ NO HOSPITALIZATION HISTORY TO REPORT.

HOSPITALIZATION	YEAR

Pinewood MEDICAL CLINIC, P.A.

PATIENT NAME: _____ DOB: _____

PINEWOOD MEDICAL CLINIC, P.A.

FAMILY HISTORY: PLEASE INDICATE THE AGE OF YOUR RELATIVES. CHECK IF ANY OF THE FOLLOWING CONDITIONS APPLY.

BLOOD RELATIVES	AGE	LIVING ?	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	MENTAL ILLNESS	CANCER (SPECIFY TYPE)	OTHER DISEASES
MOTHER		☐	☐	☐	☐	☐	☐	☐_____	
FATHER		☐	☐	☐	☐	☐	☐	☐_____	
SIBLINGS		☐	☐	☐	☐	☐	☐	☐_____	
PATERNAL GRANDPA		☐	☐	☐	☐	☐	☐	☐_____	
PATERNAL GRANDMA		☐	☐	☐	☐	☐	☐	☐_____	
MATERNAL GRANDPA		☐	☐	☐	☐	☐	☐	☐_____	
MATERNAL GRANDMA		☐	☐	☐	☐	☐	☐	☐_____	
CHILDREN		☐	☐	☐	☐	☐	☐	☐_____	

SIBLINGS: BROTHERS #: ____ SISTERS #: _____ ☐ HEALTHY?

CHILDREN: SONS #: _____ DAUGHTERS #: ____ ☐ HEALTHY?

SOCIAL HABITS: HAVE YOU EVER USED ANY OF THE FOLLOWING?

HABIT	NEVER	NOW	QUIT	AMOUNT USED / TYPE	# OF YEARS	YEAR STOPPED
TOBACCO	☐	☐	☐	PACKS PER DAY:_____ ☐ CIGARETTES ☐CIGARS ☐PIPE ☐SMOKELESS ARE YOU INTERESTED IN QUITTING? ☐YES ☐ NO		
ALCOHOL	☐	☐	☐	DRINKS PER WEEK OF: ☐ BEER_____ ☐WINE_____ ☐LIQUOR_____		
STREET DRUGS	☐	☐	☐	TYPE: ☐ POT ☐COCAINE ☐PAIN PILLS ☐ IV ☐OTHER_____		
EXERCISE	☐	☐	☐	HOURS OR SESSIONS PER WEEK: _____ TYPE: _____		
CAFFEINE	☐	☐	☐	SERVINGS PER DAY OF: ☐COFFEE_____ ☐TEA _____ ☐SODA _____		

NUTRITIONAL ASSESSMENT: DO YOU FOLLOW A SPECIAL DIET OR HAVE ANY DIETARY RESTRICTIONS?

☐ NO

☐ YES. PLEASE SPECIFY:_____

ARE YOU SEXUALLY ACTIVE?

NUMBER OF SEXUAL PARTNERS IN THE PAST 12 MONTHS:_____

DO YOU EXERCISE SAFE SEX PRECAUTIONS? ☐YES ☐ NO

WOULD YOU LIKE INFORMATION REGARDING PRECAUTIONS? ☐YES ☐ NO

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐YES ☐ NO **IF NO, WOULD YOU LIKE ONE?** ☐YES ☐ NO

Pinewood MEDICAL CLINIC, P.A.

PATIENT NAME: _____ DOB: _____

PINEWOOD MEDICAL CLINIC, P.A. |

PREVENTATIVE CARE: PLEASE WRITE THE YEAR IF YOU HAVE RECEIVED THE FOLLOWING ITEMS

IMMUNIZATIONS	**YEAR**
HEP A	
HEP B	
ZOSTAVAX (SHINGLES)	
PREVNAR (PNEUMONIA)	
PNEUMOVAX (PNEUMONIA)	
TETANUS	

HAVE YOU HAD A FLU SHOT SINCE THE MOST RECENT SEPTEMBER 1ST? ☐ YES ☐ NO

SCREENING EXAMS	**YEAR**
CHOLESTEROL / LIPID SCREENING	
STOOL FOR OCCULT BLOOD TEST	
COLONOSCOPY (> AGE 50)	

DIABETIC EYE EXAM (DIABETIC PATIENTS) YEAR: ____ FINDINGS: ☐ NORMAL ☐ RETINOPATHY ☐ MACULAR EDEMA

FACILITY OR NAME OF OPTHAMOLOGIST: _____

MALE PATIENTS ONLY	**YEAR**	**RESULTS**	**PERFORMED BY:**
PROSTATE EXAM			
PSA (BLOOD TEST)			

DO YOU PERFORM A MONTHLY TESTICULAR SELF-EXAM? ☐ YES ☐ NO

FEMALE PATIENTS ONLY	**YEAR**	**RESULTS**	**PERFORMED BY:**
MAMMOGRAM (> AGE 40)			
DEXA / BONE DENSITY (> AGE 50)			
PAP SMEAR			

DO YOU PERFORM A MONTHLY BREAST EXAM? ☐ YES ☐ NO

MENSTRUAL HISTORY: AGE AT FIRST MENSES: _____ ☐ REGULAR ☐ IRREGULAR ☐ PAIN / CRAMPS

PREGNANCY TOTAL #: _____ VAGINAL DELIVERIES #: _____ C-SECTIONS #: _____

MISCARRIAGES #: _____ ABORTIONS #: _____ COMPLICATIONS: _____

COORDINATED CARE: PLEASE LIST ANY OTHER SPECIALISTS YOU MAY SEE AND WHY.

PHYSICIAN NAME	**SPECIALTY**	**REASON**

COPING / STRESS TOLERANCE ASSESSMENT

WHO LIVES WITH YOU? ☐ ALONE ☐ SPOUSE ☐ CHILDREN ☐ PARENT(S) ☐ OTHER: _____

CURRENT STRESSORS: ☐ FAMILY ☐ FRIENDS ☐ JOB ☐ MARRIAGE ☐ MONEY ☐ OTHER: _____

IN THE PAST YEAR HAVE YOU HAD A MAJOR LOSS OR CHANGE IN YOUR LIFE? ☐ NO ☐ YES _____

X _____ _____

PATIENT SIGNATURE DATE

Pinewood MEDICAL CLINIC, P.A.

PATIENT NAME: _____ DOB: _____

PINEWOOD MEDICAL CLINIC, P.A.

PATIENT MEDICATION HISTORY

PRESCRIPTION MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY	PURPOSE

OVER THE COUNTER (OTC) MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY	PURPOSE

SUPPLEMENTS/HERBALS

SUPPLEMENT NAME	STRENGTH	FREQUENCY	PURPOSE

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ NO ☐ YES, LISTED BELOW:

_____

_____

_____

_____

X_____ _____

PATIENT SIGNATURE DATE

REVIEWED BY: _____

PINEWOOD MEDICAL CLINIC P.A. | REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____ **Age:** _____ **Sex:** _____

SSN: _____ **Race:** _____ **Ethnicity:** _____

Preferred Language (check one): English ____ **Spanish**___ **Other**_____ **Marital Status**_____

Address:_____

HOME #: _____ **Cell #:** _____ **Email:**_____

Pharmacy Name & Phone Number: _____

Primary Care Physician:_____

Address:_____ **Office #**_____**Fax #**_____

Emergency Contact Name: _____

Address/City/State/Zip Code: _____

Telephone No: _____**Cell Phone No:** _____

Guarantor's Name: _____**DOB:** _____

Address/City/State/Zip Code: _____

Telephone: _____**Driver's License No:** _____

Relationship to Patient (if "self" leave blank): _____

Employer's Name: _____

Employer Address/City/State/Zip Code: _____

Employer Telephone No: _____

Insurance Company: _____

Subscriber's ID#: _____ **Group#:** _____

Pinewood
MEDICAL CLINIC, P.A.

Circle the Provider you're seeing:

Ashley Chin, MD

Chhay (Eric) Tay,MD,ECNU

Tami Berkenhoff, PA-C

Jennifer Quinones, PA-C

PINEWOOD MEDICAL CLINIC P.A. | REGISTRATION FORM

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Pinewood Medical Clinic P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge that I have had the opportunity to view the Notice of Privacy Practices.

X_____ _____

Signature of Patient/Guardian Date

AUTHORIZATION OF MEDICAL INFORMATION TO A SECOND PARTY

I give my written authorization to release pertinent information regarding date and time of upcoming appointments, labs, diagnostic testing, referral information, and/or screening services.

You may release information to: (Name) _____

Relationship _____ Telephone Number: _____

X_____ _____

Signature of Patient/Guardian Date

PATIENT AUTHORIZATION

Notice of Privacy Practices

Your name and signature below indicates that you have been offered a copy of Pinewood Medical Clinic P.A.'s Notice of Privacy Practices. Contact Pinewood Medical Clinic at 936-321-3110.

Name (please print): _____

X_____ _____

Signature of Patient/Guardian Date

Assignment of Benefits, Financial Authority

I authorize Pinewood Medical Clinic P.A. to submit to my insurance carrier to evaluate claims for payment. I understand that if my employer is responsible for paying all or part of this claim, they will receive the medical information necessary to pay for it, and I authorize release of this information. I further authorize payment of benefits, otherwise payable to me, to be made payable to Pinewood Medical Clinic P.A. I understand that I am financially responsible for all charges not covered by my insurance.

If my insurance company is not in Pinewood Medical Clinic P.A.'s network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

X_____ _____

Signature of Patient/Guardian Date

Consent for Medical Treatment

I give permission to Pinewood Medical Clinic P.A. to perform the medical and surgical processes, treatment, and/or procedures that the clinician and other non-clinicians and assistants may deem necessary. In addition, I authorize Pinewood Medical Clinic P.A. to release any information obtained during the course of my examination and/or treatment to my healthcare insurer or other payer.

X_____ _____

Signature of Patient/Guardian Date

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. We require that you read and sign this policy prior to receiving any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS.
All patients must complete our Patient Registration and History forms before receiving treatment.

PLEASE READ AND **INITIAL** EACH PARAGRAPH:

_____ INSURANCE PAYMENTS: If, for any reason, your insurance company does not render payment within thirty (30) days from the date of service, understand that you will be responsible for that unpaid balance.

_____ ALL NETWORK PLANS AND MEDICARE: We accept assignment of insurance benefits. However, if your insurance carrier has not made any payment within sixty (60) days from the date of service, you may be billed for the balance. If the insurance company does render payment, we will gladly refund the difference. Please be aware that some, and perhaps all, of services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. All co-pays/unpaid balances must be paid up front before treatment is received.

_____ SELF-PAY OR UNINSURED: If you do not have insurance coverage, or if Pinewood Medical Clinic P.A. does not have direct contact with your insurance company, you will be required to pay in full for your visit. An initial payment for medical care/treatment, the office visit fee, will be collected at check-in. Should your treatment require more complex evaluations, lab tests, vaccines, medications, x-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

_____ HMO/POS POLICIES REQUIRING REFERRAL FROM PCP: It is the responsibility of the patient to obtain a written or verbal referral (whichever is required by the insurance carrier) prior to the patient's visit at a specialist's office. The specialist cannot obtain the referral for you.

_____ USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are not responsible for payment in excess of the insurance companies' determination of usual and customary rates.

_____ ADULT PATIENTS: Adult patients are responsible for full payment at time of service.

_____ MINOR PATIENTS: The adult accompanying a minor and/or the parent/guardian of the minor is responsible for full payment. For unaccompanied minors, all non-emergency treatment will be denied unless charges have been pre-authorized by the Financial Counselor or paid by check or credit card at the time of service.

_____ MISSED APPOINTMENTS: Unless cancelled within 24 hours in advice, our policy is to charge a $35.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

_____ DOCUMENT FEE: A documentation fee of $35.00 will be charged for all documentation that must be completed (Attending physician statements, letters of medical necessity, etc...).

Please let us know if you have any questions concerning our Financial Policy.
I HAVE READ THE FINANCIAL POLICY AND AGREE TO THE TERMS AS LISTED ON THIS PAGE.

_____ _____
Patient Name Relationship to Patient

X_____ _____
Signature of Patient or Responsible Party Date

PATIENT CENTERED MEDICAL HOME PATIENT COMPACT

A Patient Centered Medical Home is a trusting partnership between a doctor-led healthcare team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the roll of each in the total healthcare program.

We trust you, our patient, to:

- Tell us what you know about your health and illness
- Tell us about your need and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon, or let us know why you cannot so we can try to help and change the plan
- Tell us what medications you are taking and ask for refill at your office visit when you need one
- Let us know when you see other doctors and what medications they prescribe you on or change
- Ask other physicians/specialist/facilities to send us a report about your care when you see them
- Learn about your insurance so you know what it covers
- Keep your appointment as scheduled, or call and let us know you cannot at least 24 hours in advance
- Pay your share of the visit fee at time of service
- Give us feedback so we can improve our service; our feedback box is in our waiting room.
- Visit our website at www.pinewoodmedicaltx.com and use the web portal to view lab results and chart information

As we build your Medical Home, there may be changes in how we provide care. However, we will continue to:

- Provide you with your own doctor who knows you and your family whenever he/she is available
- Respect you as an individual, we will not make judgments based on race, religion, sex, or disability
- Respect your privacy, your medical information will not be shared with anyone unless you give us written permission or it is required by law
- Provider care given by a team of people led by your doctor
- Give the care you need when you need it
- Give the care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours, 7 days a week
- Take care of short, illness, long-term disease and give advice to help you stay healthy
- Tell you about your health and illness in a way you can understand

Over the next several months, you may notice that:

- We ask what your health care goal is, or what you want to do to improve your health
- We use current best evidence in decision making about your care and offer support for self-management of your health and healthcare
- We ask you to help us plan your care and let us know if you think you can follow the plan
- We will give you a written copy of the care plan
- The team care members are doing more and/or different parts of the care
- We may ask you to have blood tests done before your visits so the doctor has the results at the time of your visit.
- We may offer you a chance to join in a special type of doctor visit called a "group visit"
- We continue to increase the use of technology in the way we manage your healthcare in ways such as ePrescriptions, eMessaging, and online bill pay (Via EMR and Patient Portal)

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above, and we will acknowledge our agreement to you. Either you or your doctor may end this partnership at any time. If you choose to end the partnership, please notify us and tell us why. If your doctor decides to stop seeing you, we will notify you with an explanation as to why. With your written permission, we will forward a copy of your health records to your new physician.

Patient's Name: _____ DOB: _____

Patient Signature	Date	Physician Signature

PINEWOOD MEDICAL CLINIC P.A. | REGISTRATION FORM

HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hearby authorize use of disclosure of protected health information about me as described below. The following specific person or facility is authorized to make the requested use of disclosure:

REQUESTING RECORDS FROM:

Name of Dr. or Facility: _____

Address: _____

Phone No.: _____ Fax No.: _____

RELEASING RECORDS TO:

Name of Dr. or Facility: _____

Address: _____

Phone No.: _____ Fax No.: _____

Patient Name: _____ DOB: _____

Records requested (please check one):

_____ALL MEDICAL RECORDS _____DIAGNOSTIC STUDIES OTHER: _____
_____EKG _____BLOODWORK/LABS
_____CONSULTATION NOTES _____IMMUNIZATION RECORDS

DATES OF REQUESTED RECORDS: _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying the above mentioned facility in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____ or one (1) year after the date of said authorization.

Signature of individual: _____ Date: _____ SSN or DOB: _____

If applicable (for minors)
Signature of guardian: _____ Date _____ SSN or DOB: _____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 1/1/2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to physician, dentist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may 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.

Your 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 health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is 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. By state law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you 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 assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and pour 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We any use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19.00 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before January 1st 2010. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or may have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Lan Dao

Telephone: 936-321-3110 Fax: 936-321-3125

Address: 6318 FM 1488 Rd Suite-100

Magnolia, Texas 77354