Welcome!

We are honored you have chosen **West Texas Allergy** and have decided to trust us with your care. Our providers and staff are trained and experienced. We have implemented procedures in hopes to provide you the best medical care we can. We strive to make your visit a pleasant one and make every effort to be timely. Your appointment time has been reserved exclusively for you. Therefore, we respectfully request that you notify us as soon as possible if you are not able to keep your scheduled visit.

During your initial appointment, you will visit with one of our providers and discuss the reason for your visit with us and your allergy/asthma/immune history. Based upon the findings, it may be determined that you will need allergy skin testing. Should that be the case, we offer same-day initial testing along with your consultation, so please allow extra time for your initial appointment.

We practice Aeroallergen skin testing which is done using the prick and intradermal methods. These methods are used by board-certified allergists and are accepted as the standard method for the diagnosis of allergic disease. Skin testing is not painful can be safely performed at any age.

Depending on the history of your allergy symptoms you will be tested to common inhalant allergens including pollens, pet dander, molds and dust mites. Skin tests to common food allergens can also be included. Should your skin prick tests be negative, we might also perform intradermal skin tests to be sure that important allergen sensitivities are not missed. However, intradermal testing is not done on young children.

We require that a parent or legal guardian be present for the initial new patient appointment. We understand that there may be extenuating circumstances that make this difficult so please notify us ahead of time. Foster parents must provide legal documentation showing they have authorization from the state to obtain healthcare, including allergy testing.

Again, thank you for choosing West Texas Allergy! We look forward to meeting you!

Please use the checklist below to ensure that we will have all the information needed for your visit.

- ☑ **3 days before your appointment:** Please discontinue antihistamines to allow for potential skin testing. Examples are: ***Oral antihistamines:*** Cyproheptadine (Periactin), Hydroxyzine (Atarax, Vistaril), can be in cold/flu/sleep medications: Acrivastine (Semprex-D), Brompheniramine (in combination products), Carbinoxamine (Dimetapp, Palgic, Rondec), Cetirizine (Zyrtec, Wal-Zyr, Allertec, etc.), Chlorpheniramine (Chlor-Trimetron, Triaminic, etc.), Clemastine (Tavist), Desloratadine (Clarinex), Diphenhydramine (Benadryl, Nyquil, may end in -PM), Fexofenadine (Allegra, Allerfex), Levocetirizine (Xyzal), Loratadine (Alavert, Allerclear, Claritin, etc.), Pheniramine
  Nasal spray and/or eye drop antihistamines: Azelastine (Astelin, Astepro, Dymista), Olopatadine (Pataday, Patanase, Patanol)
  Motion sickness pill: Cyclizine (Marezine, Nausicalm,Valoid, etc.), Meclizine (Antivert, Bonine, Dramamine),
  Anti-nausea pills: Promethazine (Phenergan)
  DO NOT STOP asthma medications such as Montelukast, inhalers, or oral steroids e.g. prednisone/prednisolone/methylprednisolone. DO NOT DISCONTINUE antidepressants or psychotropic medications without consulting with your prescribing physician.
- ☑ **1 day before your appointment:** Please discontinue histamine blocking reflux medications such as ranitidine or famotidine. Proton pump inhibitors (PPIs) e.g. omeprazole, esomeprozole, lansoprazole, pantoprazole DO NOT need to be discontinued.
- ☑ Please arrive 15 minutes prior to your scheduled appointment time to complete paperwork.
- ☑ Allow 1-1/2 to 2 hours for a New Patient appointment.
- ☑ Bring your photo ID such as driver's license or identification card, insurance card, and be prepared to pay copay/amount toward your deductible.
- ☑ Bring a current list of all prescription medications, over-the-counter medications, and supplements with the dosages that you take.
- ☑ Wear comfortable clothing to allow for skin testing. This is generally done on the back or forearms.

WEST TEXAS ALLERGY NOTICE OF PRIVACY PRACTICES & FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

NOTICE OF PRIVACY PRACTICES

West Texas Allergy (WTA) has a responsibility to protect the privacy of your health care information. We maintain a record of the healthcare services we provide you. We will share this information, as permitted by law, to provide and coordinate your medical treatment, bill for these services, and conduct usual health care operations. You have the right to review, obtain a copy, or request to amend the record if needed. Our Notice of Privacy Practices describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. We may change the Notice of Privacy Practices at any time. If you would like a complete copy please ask the front desk.

FINANCIAL POLICY

1. ***Payment for all medical care is the patient's responsibility regardless of insurance coverage.***
2. Patient Information/Proof of Insurance: At each visit, please be prepared to present your insurance card as proof of insurance.
3. Insurance: We participate in most insurance plans and will submit claims on your behalf to the insurance company. **Knowing your insurance benefits and rules is your responsibility**. We highly encourage you to call to verify your own benefits along withany limitations you may have on your policy. If your plan has limitations, it is your responsibility to share these limitations with the provider prior to having any procedures performed. If your insurance company requires a specialist referral from your primarycare physician, it is your responsibility to obtain that referral prior to scheduling your appointment. Referrals (including allergy shots, biologic treatments, and procedures) must be up-to-date and on file prior to all appointments. You will be responsible forany charges resulting from an out-of-date referral. As a courtesy to you we have our benefit coordinator call your insurance and check your allergy benefits. While these are NOT a guarantee of payment it can help give you an idea of your patient responsibility. Again, we encourage you to call and verify your own benefits.
4. Co-payments and deductibles: **Co-pays must be paid at the time of service**. Parent or adults accompanying a minor will be responsible for the patient's co-pay and bill at that visit. If insurance discloses that there is an unfulfilled deductible over $300 for a new patient or over $150 for an established patient, you may be required to make a minimum down payment of $300 at the initial visit or $150 at the established visit. The remainingbalance will be due at the time of receipt of your invoice (billing statement).
    1. Patients who **DO NOT** have insurance coverage will be expected to pay at the time of service. New patient visits can range from $500 to $1700 depending on services done while in the office. We do offer a 15% discount for same-day-payment of services. If you cannot pay the full amount due, **we do ask that you pay at least $300 on the date of service** and payment arrangements can be made for the remainder of your balance. For your convenience we accept cash, check, MasterCard, Visa and American Express.
5. Non-covered services: Our providers follow appropriate medical guidelines for standards of care based on your medical condition. Please be aware that some of the services you receive may be determined by your insurance plan to be only partially covered or not covered. **You will be responsible for the cost of services that is not paid by insurance.**
6. Claims submission: We will bill your insurance company on your behalf. You are responsible to know your own insurance benefits. Coverage, co-payments, co-insurance and deductibles can change on an annual basis. If there is a change in your insurance coverage, please notify the clinic as soon as possible. Some insurance companies have time limits on when claims need to be submitted. If we do not have the correct information, we cannot file the claim in a timely manner and the financial burden becomes yours.
7. Account balances: All account balances are due upon receipt of your billing statement. If the account remains unpaid after 90 days, it will be referred to a third party collector. Failure to pay the account balance may result in discharge from the practice, including family members who are also patients. In such case, you may request that your medical records be transferred to another provider at no charge. If, after being discharged, you would like to be considered for reinstatement to the practice, all financial obligations must be paid in full. Reinstated patients are required to maintain a credit card on file.

8. Release of Information: I hereby authorize the physician and/or staff of West Texas Allergy, to release any information required to process all my claims for any current/future treatment unless rescinded by me in writing.
9. Assignment of Benefits: I authorize payment of medical benefits to West Texas Allergy for services performed. I also understand that any and ALL services (including allergy serum/extract) that are NOT covered by the insurance will by MY responsibility.
10. Medicaid: I authorize payment of medical benefits to West Texas Allergy for services performed. I understand that West Texas Allergy does not accept retro-active Medicaid and any services performed during that time will be my responsibility. **Should my Medicaid coverage change, I understand that it is my responsibility to get my information to West Texas Allergy within 30 days of the change in order for my claims to be processed and filed with Medicaid, otherwise it will become my responsibility.** I also understand that any and ALL services (including allergy serum and/or drops) that are NOT covered by the insurance will by MY responsibility.
11. Medicare Authorization: I request that payment of authorized Medicare benefits be made on my behalf to West Texas Allergy for any services furnished. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.
    1. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of the HCFA-1500 form or elsewhere on the approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Medicare does not pay for everything, even some care that I or my health care provider have good reason to think I need (example: ingestion challenge); however it is my discretion whether or not I want to receive services not covered but do understand that it will be financially my responsibility and not Medicare's. I know that I can speak with the billing office should I have more questions.
12. Returned checks: Any non-sufficient fund checks will be charged a $35 fee.
13. Patient Portal: We ask that you sign up for our patient portal. There you can store your credit card, pay your bill and more. If you do not get your email to login, please call our office to help you get set up.
14. Divorce/Separation: In cases of divorce and/or separation, the legal guardian and/or the person completing paperwork and/or bringing the child in for the **initial** visit will be considered the Guarantor and will be held responsible for paying any medical services. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person,you will be held responsible for the balance on your child's account.

I have reviewed a copy of the Notice of Privacy Practices which provides information about how my health information may be used and disclosed. I have read and understand the Financial Policy of West Texas Allergy (WTA). I assign payment from my insurance directly to WTA. I understand that I am financially responsible to WTA for the charges not paid by insurance and that those charges are due upon receipt of invoice (billing statement).

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative,have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that WTA participates in the training of physicians and other healthcare providers and consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at or by WTA.

Patient/Guarantor Signature	Date
Printed Name of Signature Above	Relationship to Patient
Patient's Name	Date of Birth / Acct # (office use)

Patient Instruction and Consent Form for Allergy Skin Testing

During your consultation with our providers, it may be deemed necessary for you to do allergy skin testing. In the event I should need skin testing by signing this form I give my consent to do any necessary allergy testing.

Skin Test: Skin tests are methods of testing for allergic antibodies. These tests are not very invasive and tend to produce quick results. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 minutes after the application of the allergen. If the results of the prick/scratch tests are negative, they may be followed by intradermal tests, which can give the allergist more details about what's causing the underlying symptoms.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms. You will be tested to airborne allergens and possibly some foods. These include, trees, grasses, weeds, molds, dust mites, and animal danders and, possibly some foods. Prick (also known as percutaneous) tests are usually performed on your back but may also be performed on your arms. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. On a rare occasion a reaction other than localized itching, such as runny nose, congestion, itchy eyes, nose or throat might occur due to the skin testing, however; our staff has been thoroughly trained to handle an any issue should it occur.

I have read over the skin testing details above and understand it and know that I can ask any further questions I might have during my consultation with a provider. I also understand that I may choose not to do allergy skin testing and will inform the provider if I should choose not to.

By signing this form, I authorize West Texas Allergy to do skin testing on me should it be deemed necessary. I understand that every precaution consistent with the best medical practice will be carried out. I understand that allergy testing may/may not be covered under my insurance or it may/may not go to my deductible. Knowing your insurance benefits and rules is your responsibility. We highly encourage you to call to verify your own benefits along with any limitations you may have on your policy. If your plan has limitations, it is your responsibility to share these limitations with the provider prior to having any procedures performed. As a courtesy to you we have our benefit coordinator call your insurance and check your allergy benefits. While these are NOT a guarantee of payment it can help give you an idea of your patient responsibility.

Patient/Guarantor Signature	Date
Printed Name of Signature Above	Relationship to Patient
Patient's Name	Date of Birth / Acct # (office use)

Midland Location
5000 Briarwood Avenue, 79707
(p) 432. 682.5385, (f) 432. 682.1265

West Texas Allergy

Lubbock Location
5424 19th St. Suite 300, 79407
(p) 806.795.4391, (f) 806.796.1354

WEST TEXAS ALLERGY

CONSENT TO DISCUSS MEDICAL CARE FOR
ADULT PATIENTS ≥18 years of age
(please complete separate Consent to Treat/Discuss for MINORS)

Many of our patients allow family members such as a spouse, parent(s)/legal guardian(s), grandparent(s), sibling(s) or children, or others such as a caregiver or friend to call and discuss medical information, request appointments, prescriptions, vaccine information, medical records, test results, or pick up forms, etc. Under the requirements of HIPAA, we are not allowed to give this information to anyone without a patient's consent. If you wish to have your medical information released to others, please complete this form. Signing this form will only give your consent to release information to the individual(s) listed below.

I authorize West Texas Allergy to share and/or release my medical information to the following individuals:

Please PRINT names listed below (Do not list physicians)

Name: _____ Relationship to patient: _____ Phone Number(s):_____

Name: _____ Relationship to patient: _____ Phone Number(s):_____

Name: _____ Relationship to patient: _____ Phone Number(s):_____

Name: _____ Relationship to patient: _____ Phone Number(s):_____

Name: _____ Relationship to patient: _____ Phone Number(s):_____

□ Or, I decline permission to verbally discuss my medical information with others.

I request that all communications to me (by telephone, mail, electronic mail or otherwise) by West Texas Allery and staff are handled as follows:

- For WRITTEN Communication Address to:

_____

- For ORAL Communication Call:

Home: _____ May we leave a message? Yes No

Work: _____ May we leave a message? Yes No

Cell: _____ May we leave a message? Yes No

- Electronic Mail Communication to E-mail Address: _____

I understand that I can cancel this consent at any time (by writing to West Texas Allergy) but that cancelling it will not affect any information that has already been released.

Date: _____ Signed: _____

patient or representative

If not patient – my relationship to the patient is: _____.

Consent for Treatment of a Child/Minor WITH or WITHOUT Parent or Legal Guardian Present

Date _____

Name of Patient _____

Patient's Date of Birth _____

Printed Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____

Please initial the items below.

_____ I am the parent/guardian of the above-named patient. I have the legal right to consent to medical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment and diagnostic tests and/or allergy injections that WTA believes are necessary for this child. I understand that by signing this form, I am giving permission to this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent. I also agree for my minor child(ren) to have additional emergency care if warranted, including the utilization of 911, emergency room and/or hospitalization.

_____ In agreement with federal and state law, I agree to allow WTA to deliver the necessary care to this child in order to provide continuity of care and treatment. WTA may obtain from any source examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

_____ I voluntarily authorize WTA to allow E-Prescribing for the patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.

_____ I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

_____ I understand all copays/payments must be paid at the time of service. I also agree to accept financial repsonsibilyt for all care and services delivered pursuant to this authorization (including but not limited to ordering more serum.) I understand that whoever brings in my minor child will be expected to bring in a valid ID.

Minors <u>under</u> age 16 unaccompanied by a parent or legal guardian:

_____ I understand that it is the policy of WTA that minors under the age of 16 are to be accompanied by a responsible adult, <u>being at least 18 years of age</u>, to **office visits or to receive allergy injections**. If I am unable to accompany my child, I give permission to the following person/people to bring them instead. I give permission for treatment (office visit or shots) to be given without my presence. I understand that adverse reactions can occasionally happen and also give permission for any treatment that might be needed in the event of complications or adverse reactions.

Name or person to accompany child: _____

Minors age <u>16 or older</u> unaccompanied by a parent or legal guardian:

_____ I authorize West Texas Allergy to treat the above-named minor for an office visit and/or injections (allergy/etc.) without my presence or the presence of another accompanying adult in the building. Further, I acknowledge that I am this patient's parent or legal guardian.

Patient Information

Name: _____
Last *First* *Middle Initial*

Soc. Sec. #:_____Birthdate: _____

Did a physician refer you to see us? ( ) Yes ( ) No

If yes, Doctor's Name: _____

If a physician did not refer you, how did you hear about us? _____

Primary Care Physician's Name: _____

Reason for Visit: _____

How long have you had this condition? _____

Describe the most distressing symptoms you feel are caused by your allergy:

_____

_____

_____

List all medications you have tried in the past for allergy (all oral, topical and nasal sprays) and the response you had to each:

_____ _____

_____ _____

_____ _____

Known Allergies to Medications (List names and symptoms you had):

_____

_____

All Current Medications (include allergy medications):

_____

_____

_____

_____

Patient ID: _____

NOTICE OF PRIVACY PRACTICES

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

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.

If you have any questions about this Notice please contact the office manager.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. 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 protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Practice Manager at 432.682.5385 for further information about the complaint process.