

Progressive Health Family Medicine, PLLC

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:		First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one): Single / Married / Divorced / Widow / Other	
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number:		Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other			
Mailing Address:			City / State:			Zip Code:	
Primary Phone:		Alternate Phone:			<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call back information only <input type="checkbox"/> OK to mail written communication to my address		
Occupation:		Employer:		Work Phone:			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Location	<input type="checkbox"/> Yellow Pages / Internet	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Carrier:		ID / Policy Number:	Group Number:	Primary Policy Holder Name:			
Relationship to Patient? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____				Date of Birth: _____			
Secondary Insurance Carrier:		ID / Policy Number:	Group Number:	Primary Policy Holder Name:			
Relationship to Patient? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____				Date of Birth: _____			

EMERGENCY CONTACTS

Name of relative or friend:	Relationship to patient:	Phone Number:
Name of relative or friend:	Relationship to patient:	Phone Number:

PHARMACY INFORMATION

Pharmacy Name:	
Address / Intersection:	Phone Number:

AUTHORIZATION / CONSENT

The above information is correct to the best of my knowledge. I authorize Progressive Health Family Medicine, PLLC to:

- File an insurance claim(s) on my behalf based on the information I provided and I will receive an Explanation of Benefits (EOB) from my insurance carrier(s) that will detail any payments, deductions, and adjustments per my individual insurance plan's guidelines.
- Request my insurance benefits be paid directly to Progressive Health Family Medicine, PLLC for services rendered at this location.
- Release any information to my insurance company that is required to process my medical claims.
- View my prescription history from external sources.

I hereby provide consent for medical treatment by Progressive Health Family Medicine, PLLC.

Patient signature:

Date:

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	GASTROINTESTINAL <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	EYE, EAR, NOSE, THROAT <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos	MEN only <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
MUSCLE/JOINT/BONE Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	CARDIOVASCULAR <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	WOMEN only <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS List medications you are currently taking.	ALLERGIES To medications or substances

Pharmacy Name _____ Phone _____

**Progressive Health Family Medicine, PLLC
8901 Virginia Parkway, Suite 700
McKinney, TX 75071
(972) 369-1871 – phone
(972) 369-1872 – fax**

**** To avoid repeated fax requests, please attach this request as a cover sheet to your fax****

Patient Name: _____

Date of Request: _____ **Date of Birth:** _____

Records requested from the following physician / facility:

Name: _____

Phone: _____

Fax: _____

Please forward the following:

_____ All medical records _____ Test only (specify) _____

Please fax to the attention of:

Hema Haridas, M.D.

By signing below, I am providing written consent for Progressive Health Family Medicine, PLLC to obtain copies of my medical records. I also agree that photocopied signatures are valid for obtaining medical records.

Patient Signature

Witness Signature

Mission Statement

Progressive Health Family Medicine, PLLC is committed to providing patients with high-quality health care. We believe that providing optimal care is not only about the medical advice and treatment that we dispense, but more importantly about the relationships that we have with our patients. We continue to strive to deliver comprehensive, patient centered, timely, cost efficient care to our patients in order to optimize their quality of life.

Our Physicians

Our physicians are primary care doctors specialized in Family Practice. All of our physicians are board certified by the American Board of Family Medicine. We provide preventative care and management of chronic illnesses such as diabetes, high blood pressure, and cholesterol, as well as acute care to patients.

Office Hours

For your convenience, our office is open Monday through Friday with morning and afternoon appointments available. In most cases, we have same day appointments available for your urgent care needs. If you are unable to keep an appointment, please give 24 hours notice of your cancellation so we can provide the opportunity for another patient to be seen in your time slot.

Referrals

If a physician refers you to a specialist or schedules additional diagnostic testing, we will provide the referral from your insurance company if necessary. We require at least two business days advance notice to be able to provide quality medical care and referral evaluation. We will also work with the specialist or testing facility to coordinate your medical care. Patients are ultimately responsible for understanding their insurance policy's guidelines for specialty care and any costs associated with care received beyond our practice.

Prescriptions and Refills

We are always happy to provide prescription refill requests to our patients when medically approved. We require at least two business advance notice to be able to provide quality medical care and prescription evaluation. You may visit or call your pharmacy to request any refills you may need. Unfortunately, refills cannot be called in on weekends or holidays We strongly encourage you to notify your pharmacy or our office at least three days before your prescription runs out. Your health is our top priority; therefore, refills will be authorized as needed provided you follow up in the office as recommended by the physician.

In Case of Emergency

We realize that emergency situations arise. If you require urgent medical care, call us anytime at (972)369-1871 and the office will try to arrange for a same day appointment with your physician or the first available physician. If the problem is life threatening, call 9-1-1 or proceed to the nearest emergency room for treatment.

In an effort for my physician to provide me with optimal medical care, I understand the above policies and procedures.

Patient Signature

Date

PROGRESSIVE HEALTH FAMILY MEDICINE, PLLC FINANCIAL POLICY

NAME: _____

DATE OF BIRTH: _____

Thank you for choosing Progressive Health Family Medicine, PLLC as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.** If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. **It is ultimately your responsibility to know and understand the types of services covered and reimbursements provided by your insurance company.**
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for any services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company.
- **Co-payments, coinsurance, and/or deductibles are due at the time of service.** We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- **Patients without insurance coverage are required to pay the balance in full at the time of service.**
- We do not file claims to any Workers Compensation programs or on claims for automobile-related accidents.
- It is your responsibility to provide us with your most current billing information. Please provide your most current billing address, all available telephone numbers, and any other important contact information. If your address or contact information changes, please contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, please contact our business office within 30-days after receipt of the initial statement. You can call **(972) 369-1871**.
- **We accept cash, credit cards, debit cards, and most Flex Med cards as forms of payment.**
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be referred to a professional collection agency for further collection activity.**
- If you are not able to pay the balance due in full, please contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency.
- **If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Progressive Health Family Medicine, PLLC** Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

I have read and understand this Financial Policy.

Patient Signature

Date

Progressive Health Family Medicine, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain protected health information. I understand Progressive Health Family Medicine, PLLC reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy to me in writing.

Persons Authorized to Receive Information:

The following names are of people I authorize to have access to my protected health information. I give permission for Progressive Health Family Medicine, PLLC to share my protected health information with:

Name Relationship

Name Relationship

Name Relationship

I authorize the person(s) listed above to receive information about appointments, treatments, and/or other information pertinent to my healthcare and relationship with Progressive Health Family Medicine, PLLC.

_____ I do NOT authorize any information to be disclosed to any other parties other than those outlined in the Notice of Privacy Practices.

Information Release to Other Healthcare Professionals:

I authorize Progressive Health Family Medicine, PLLC to release any pertinent medical information to other healthcare professionals directly involved in my medical care. This includes lab results, radiology reports, physician notes, prescription information, treatment plans, etc.

Expiration Date of Authorization:

This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

Signatures:

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Witness Signature

PROGRESSIVE HEALTH FAMILY MEDICINE, PLLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER AT (972) 369-1871.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) 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 that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services.

We are required to maintain the privacy of protected health information and 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. An updated copy will also be posted in our office.

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 that 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 the physician's practice. The following are examples of the types of uses and disclosures of your protected health care information that the 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 a third party that has already obtained your permission to have access to your protected health information. 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 radiologist or pathologist) 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, as needed, to obtain payment for your health care services. 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.

Healthcare (Clinic) Operations: We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

For example, we may call you by your name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing services, transcription services, etc.) for the 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 protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest 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, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object. 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. In this case, only the protected health information that is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instances:

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person 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.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

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

We may use or disclose your protected health information in the following situations without your authorization. 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, as 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. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

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 abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse,

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NOTICE OF PRIVACY PRACTICES

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 to report adverse events, product defects or problems, biologic product deviations, 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), 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 the practice, and (6) medical emergency (not on the 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: If you choose to participate in medical or scientific 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: Your protected health information may be disclosed by us 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.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

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 that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about your health care. The request must be made in writing to **Progressive Health Family Medicine, PLLC**. If you request a copy of your medical record, your physician's office will provide you a copy within 30 days.

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 protected health information that is 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 healthcare 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 believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. 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.

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 as long as we maintain this information for the purpose of correcting an error or misinformation. 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 that statement will become part of your medical record. Your physician may prepare a rebuttal to your statement which will also become part of your medical record. Your physician 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 healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. 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.

3. Questions or Complaints

If you have a question or complaint about your privacy rights, please file a grievance form with the Privacy Officer of Progressive Health Family Medicine, PLLC at 8901 Virginia Parkway, Suite 700, McKinney, TX 75071. Should the Privacy Officer be unable to resolve your complaint to your satisfaction, you may contact the Secretary of Health and Human Services.

This notice is effective January 1, 2011.