



PATIENT INFORMATION

Patient _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Social Security # _____ Email Address _____
Employer _____ Work # _____
Employer Address _____
City _____ State _____ Zip Code _____
Spouse's Name _____
Spouse's Employer _____ Work # _____
Emergency Contact _____ Phone # _____
Referring Physician _____
How Did You Hear About Woodlands Pain Consultants? _____

INSURANCE INFORMATION

Insurance Name _____ Insurance Name _____
Address _____ Address _____

Phone # _____ Phone # _____
ID # _____ ID # _____
Group # _____ Group # _____

AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim and request payment of medical benefits be made to Woodlands Pain Consultants, P.A./ Lenny Q. Jue, M.D.

Signature _____ Date _____

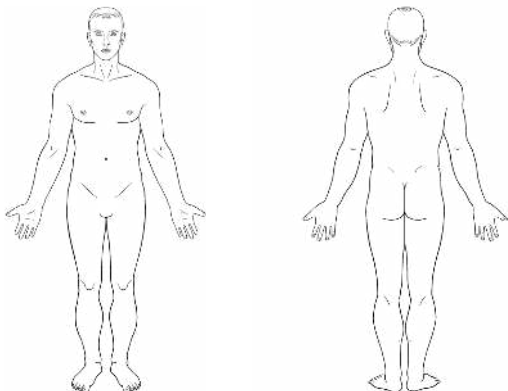
PAIN ASSESSMENT QUESTIONNAIRE

Date _____ Referring MD _____

Name _____

Age _____

Location of Pain _____



Pain is: constant comes and goes

RATE YOUR PAIN USING THIS SCALE:

1 2 3 4 5 6 7 8 9 10

no pain moderate severe

at your worst times: _____ at your best times: _____

DESCRIBE YOUR PAIN (*Circle all that apply*)

Throbbing Shooting Stabbing Sharp Cramping

Aching Burning Gnawing Dull Sore Crushing

Heavy Tingling Numb Pressing Squeezing

WHAT MAKES THE PAIN BETTER?

WHAT MAKES THE PAIN WORSE?

ARE YOU SLEEPING WELL? YES NO

IS YOUR INJURY WORK-RELATED?

IF YES, DATE OF INJURY

ARE YOU INVOLVED IN A LAWSUIT?

NAME OTHER TREATING PHYSICIANS

MEDICAL TREATMENTS FOR PAIN

(*Circle all that apply*)

Bed Rest Physical Therapy Chiropractic

Acupuncture TENS Traction

Ultrasound Massage Pool Biofeedback

List of previous pain medication

Injections: epidural steroids

Others _____

IMAGING STUDIES (*Circle all that apply*)

X-rays MRI CT Scan Myelogram

EMG / Nerve Conduction Test Bone Scan

Others _____

PAST MEDICAL PROBLEMS

PAST SURGERIES

ALLERGIES TO MEDICATIONS

FAMILY HISTORY

SOCIAL HISTORY

OCCUPATION: _____

MARITAL STATUS: SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____

DO YOU SMOKE? YES / NO HOW MUCH? _____

IF A FORMER SMOKER, WHEN DID YOU QUIT? _____

DO YOU DRINK ALCOHOL? YES / NO HOW MUCH? _____

DO YOU HAVE A HISTORY OF ALCOHOL OR DRUG ABUSE? YES _____ NO _____

DO YOU EXERCISE? YES / NO HOW OFTEN? _____

REVIEW OF SYSTEMS *(Please circle if any of the following apply)*

Constitutional

Fever

Chills

Nausea

Vomiting

Unusual Tiredness

Endocrine

Unusual Sweating

Loss of appetite

Unexplained weight loss

Skin

Rashes

Itching

ENT

Hearing loss

Oral/Nasal Discharge

Sore Throat

Sinus Problem

Cardiovascular

Chest Pain

Shortness of breath

Arrhythmia

Respiratory

Heavy cough

Trouble breathing

Change in Sputum

Hematologic/Lymphatic

Easy bruising or bleeding

Abnormal lumps or bumps

Swollen glands

GI/GU

Change in bowel/bladder habits

Blood in urine or stool

Impotence

Eyes

Change in vision

Abnormal discharge

Neuro

Seizures

Syncope

Tingling

Weakness

Musculoskeletal

Traumatic Injury

Joint Swelling

Mood

Depression

Changes in mood

Sleep problems

ALL CURRENT MEDICATIONS

Name _____ Date of Birth _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

17. _____

18. _____

19. _____

20. _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	Never	Seldom	Sometimes	Often	Very Often
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any additional information you wish about the above answers. Thank you.

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***DUE TO NEW STATE REGULATIONS, PLEASE ALLOW UP TO 3 BUSINESS
DAYS TO PROCESS ALL REFILL REQUESTS.
PLEASE PLAN ACCORDINGLY***

Patient Name: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Address: _____

Phone: _____

Patient Signature: _____

WOODLANDS PAIN CONSULTANTS

MEDICATION AGREEMENT FORM

We are committed to doing all we can do to treat your pain condition. In some cases, controlled substances are used as a therapeutic option in the management of pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words 'we' and 'our' refer to the facility and the words 'I', 'you', 'me', or 'my' refer to you, the patient.

1. All controlled substances must come from the physician whose name appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose name appear below all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly withhold facts from a physician or his/her staff (Including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed.
3. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility. New patients will be required to provide a specimen on the day of his/her first consultation visit. We are required by law to run a report from the prescription monitoring program used by the DEA.
5. I will not consume excess amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose name appears below or during his/her absence, the covering physician, as set forth in Section 1 above. I will not use, purchase, or otherwise obtain illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including prescribed controlled substance, or any combination of substances (e.g. alcohol and prescription drugs) which impairs my driving ability, may result in DUI charge.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone prescriptions after hours, on weekends, and on holidays. Please do not call for a refill or ask the pharmacy to fax a refill request unless an exception has been made by the physician whose name appears below. Please allow up to 3 business days for refills to be completed.
8. In the event that you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
9. I understand that some prescription medications in the treatment of pain may be habit forming and dependence can occur.
10. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances by this physician and other physicians at the facility and that law enforcement officials may be contacted.
11. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Patient's Full Name: _____

Patient's Signature: _____ Date: _____

Physician's Name: LENNY Q. JUE, M.D.

PRIVACY NOTICE

To our patients:

Effective April 14, 2003, to comply with the Health Insurance Portability and Accounting Act (HIPPA), this office must inform you of the following:

You, as our patient, have a right to have your medical record information kept confidential; however, we reserve the right to use the information in those records for treatment, payment, and health care operations. We will disclose information in your medical records to only yourself and (if you wish) to one other person you designate. If you wish this person to also have access to your medical records, please fill in the following information so that we can verify his or her identity:

Name of the other person: _____

Date of birth of the other person: _____

City of birth of the other person: _____

If at any time you wish to withdraw this person's access to your medical records, please inform us immediately.

Our physicians and nurses will use the information to treat you; our billing office will use the information to bill you and your insurance company; our office will use the information for business purposes such as quality improvement and to send you information.

If you as our patient wish to have a family member, alternate physician or legal representation obtain information regarding your healthcare, we ask that you sign a medical release before we can release any information to them.

The right to access your medical records:

Patients have the right to see and get copies of their own records. We do charge for making copies of your records to cover our cost and staff time involved.

You have the right to view your records within a certain time limit after requesting them, 15 days for records kept on site and 30 days for records kept off site. The office can ask a patient for an extension in writing and by stating the reason for the request.

The right to request restrictions:

Patients have the right to restrict who sees their records. For example, the patient may ask that a spouse or family member not see the record. Sometimes the request is not feasible.

If a family member works at the office, they will have limited access to the record. If this is the case, you will have the option of changing to another physician.

The right to confidential communication:

Patients have the right to receive communication about their records in a confidential manner. Please let our staff know where you prefer to be contacted. On the intake form you are asked for a daytime phone number. If this is your work number and you prefer we do not contact you there, please list only your home phone number.

The right to amend the records:

Patients have the right to request amendment to their records when they disagree with the content. At the same time, doctors have the right to deny those requests. Remember that once written, a record cannot be changed. The doctor will be able to draw a line through the disputed entry, initial and date it, and write an addendum, or the doctor can add a statement that this is the patient's view of the situation.

The right to an accounting of disclosures:

Patients have the right to know everyone to who the office discloses record information for purposes other than treatment, payment, and health care operations.

I request the following restrictions to the use or disclosure of my medical information:

I have read and understand the privacy policy.

Signature of Patient: _____

Date: _____

WOODLANDS PAIN CONSULTANTS

Lenny Jue, M.D.

1441 Woodstead Court Suite 260
The Woodlands, TX 77380
Tel: (281) 825-4390
Fax: (281) 825-4393

FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with the highest quality surgical care at an affordable cost. To make our service available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER, OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS.
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Dishonored checks will be charged back to the patient's account with a service fee of \$25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor of collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeons' office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claim to be your responsibility for the reasons of annual deductible, co-payment, non-covered services, and non-medically necessary.

If a patient chooses or is required to bill his/her own insurance the office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles co-insurance and co-pay to many eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you are aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologist, pathologist, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of service from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient. However we have no power to charge your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at a lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage or non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Most health plans or Insurance Policies may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain per-certification if applicable for all services as a courtesy to you before your surgery.

Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupation Code • Section 120.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my information consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and /or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA, and the Section 102.006 of Texas Occupations Code.

Doctor or Facility with affiliation and remuneration: _____

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing such as insurance inquires, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provided us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within live (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for your to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff member at our office is ready to help you at all times.

If you have any question regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____	_____	_____
Signature of Patient or Responsible Party	Patient Name (print)	Date

_____	_____	_____
Signature of Co-Responsible Party	Your Name (print)	Date

DISCLOSURE OF OWNERSHIP INTEREST

In accordance with Title 22 or the Texas Administrative Code 190.8(2)(H), the following ownership disclosure is made in advance of any services you may receive at another facility.

Lenny Quan Jue, MO has an ownership interest in the entities listed below:

- Memorial Hermann Surgery Center Woodlands Parkway
- Oaks Surgical Center
- Shenandoah Imaging
- Forest Landing Surgery Center
- Anesthesia Consultants of The Woodlands
- YSC Ventures
- Houston and Spine Affiliates

Dr. Jue believes that these interests allow him greater influence over the care that his patients receive. This also allows him to have a voice in administration and policies of the facilities where you will be receiving services. This involvement helps to ensure the highest quality of care for you.

You may or may not be referred to one of these entities during the course of your treatment. In the event that you are referred for a service at one of these facilities, you do have the option of using another health care facility if you so choose. Please note that Dr. Jue may only perform procedures at facilities where he maintains privileges to do so.

If you have any questions or concerns, please feel free to discuss them with Dr. Jue.

Acknowledgement of Disclosure

Your signature on the bottom of this form signifies that you have read and understand this disclosure and that you can direct any questions and/or concerns regarding this disclosure to Dr. Jue during your visit.

Signature of Patient/Legal Representative

Date

Printed Name of Patient/Legal Representative

WOODLANDS PAIN CONSULTANTS, PA

Dr. Lenny Jue, M.D.

As a patient of Woodlands Pain consultants with Dr. Lenny Jue I have the right to ask for a chaperone at any time during the office visit or examination. Please feel free to bring someone with you or ask the medical staff to be present during the exam with Dr. Jue.

Date: _____

Printed Name: _____

Signature: _____

Woodlands Pain Consultants, P.A.

Notice of Privacy Practices

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

Please review carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You may request a copy of this notice at any time. For more information about this notices or our privacy practices and policies, please contact our office manager.

Our Responsibilities

We are required by law to maintain the privacy of our health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When you receive treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insure or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment for services rendered.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations; which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services or a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosure That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose, or use, your medical information without your written authorization or any opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses or disclosures. However, any revocation will not apply to disclose information already made or taken in relation to the original authorization.

Public Health Abuse or Neglect and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceeding and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena
- Pertains to a victim of a crime and you are incapacitated
- Pertains to a person who had died under circumstances that may be related to criminal conduct
- Is about a victim of a crime and we are unable to obtain this person's agreement
- Is released because of a crime that has occurred on these premises, or
- Is released to locate a fugitive, missing person, or suspect

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation

We may disclose your medical information as required by the Texas Worker's Compensation law.

Inmates

If you are in inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies may be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to Christi Page.

We can refuse to provide some of the information you request to inspect or have copied if the information:

- Includes psychotherapy notes
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation

We can refuse to provide access to, or copies, of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider, who was involved in the prior decision to deny access, will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost fee. The Texas State Board of Medical Examiners (TSBME) has set limits of fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to Christi Page. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice of the physicians here in this practice
- Is not part of the Designated Record Set
- Is not available for inspection because of an appropriate denial
- If the information is accurate and complete

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made, and tell others that we now have the incorrect information.

Accounting of Certain Disclosers

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosure that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for accounting to Christi Page. Your first accounting of disclosures (within a 12 month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment, and other Health-Related Benefits

We may contact you by telephone or mail to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government of us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd, CS-24-04
Baltimore, MD 21244

You will not be penalized for filing a complaint.

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, and to provide you with this notice or our privacy practices in effect.

Questions and Contact Person for Request

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Christi Page
1441 Woodstead Court Suite 260
The Woodlands, TX 77380
(281) 825-4390

This notice is effective on the following date: January 1, 2019

We may change our policies, and this notice, at any time and have those revised policies apply to all the protected health information we maintain. If or when change our notice, we will post the new notice in the office where it can be seen.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorization activities for the provision of protective services for the President of the United States, other authorized government officials, and foreign heads of state.

Required by Law

We may release your medical information where the disclosure is required by law.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by the Institutional Review Board, or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye; or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Your Rights Under Federal Privacy Regulations

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to Christi Page.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternate Means

You may request that we send communications or protected health information by alternative means or to an alternative locations. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you, and if you are directing us to send it to a particular place, the contact/address information.

Changes to this Notice

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

ATTENTION:

**AS OF FEBUARY 1, 2019 THERE WILL BE
A FEE OF \$35 FOR ANY MISSED OFFICE
VISIT WITHOUT 24 HOURS NOTICE.
THERE WILL BE A \$50 FOR A "NO CALL, NO
SHOW" TO A PROCEDURE.**

Patient Signature: _____

Patient Name: _____

Date: _____