PREMIER PLASTIC SURGERY
OF
TEXAS

Cosmetic, Plastic & Reconstructive Surgery
Peripheral Nerve Surgery

Dear New Patient:

Welcome to my practice. My staff and I look forward to meeting you at the consultation you have scheduled on:

Date: _____ Time: _____

Enclosed you will find patient information forms to be completed prior to your consultation. **If a REFERRAL from your insurance company is required please contact your primary care physician. All appointments without the proper information required will be rescheduled.** Please be sure to complete your health survey as accurately as possible. This is very important for patients who will require surgery. All medications listed must have names spelled correctly, strength or dosage listed and times taken per day. Surgeries must be listed as well, with specific type and time frame if not exact dates. If you wish to complete the paperwork at our office, please arrive 15 to 20 minutes prior to your scheduled appointment time. You are encouraged to bring any questions, references or photographs that you feel you wish to share while discussing your appearance goals.

During your consultation, you will meet with me and with other members of my staff. We are all here to educate and guide you through your choices. Prior to your consultation, please have all medical records pertaining to your current medical problem sent to us by your referring physician. If there are a large volume of records please be considerate of the physician's time and drop them off 2-3 weeks before your consultation for review. If you require more time or have additional questions, a second consultation may be scheduled.

A minimum of 2 business days is required for any cancelled or rescheduled appointments. Patients arriving 15 minutes later than the listed arrival time above will be rescheduled.

I want to thank you for choosing my practice. I am dedicated to the highest standards of patient safety. Your safety requires that patient and surgeon work as partners to understand and fulfill your goals. My staff and I look forward to meeting you.

Yours truly,
Patty Young M.D.

Patty Young, MD

4104 West 15th Street, Suite 200, Plano, TX 75093
Phone: (972) 398-1131 Fax: (972) 398-0199
www.pattyyoungmd.com

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ATTENTION NEW PATIENTS:

Please bring all your medication bottles with you to your appointment. We must have the correct information on file with regards to the drugs name, dosage and frequency taken.

We thank you in advance for your cooperation in this matter.

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PATIENT HEALTH SURVEY

Name _____ **Date** _____
Age _____ **Sex** _____ **Height** _____ **Weight** _____

Reason for office visit:
_____
_____

List all doctors involved in your care. Include full name, specialty, address, phone number:
Referring physician: _____
Personal physician: _____
_____
_____
_____
_____

Medical History Check those that apply

Cardiovascular
____High blood pressure
____Heart attack
____Coronary artery disease
____Irregular heart beats
____Heart murmur
____Heart failure
____High cholesterol
____Vascular Disease
____Blood Clots

Urinary / GI
____ Kidney stones
____ Problem voiding
____ Kidney disease
____ GERD
____ Ulcer
____ Hepatitis
____ Pancreatitis
____ Colitis
____ GI Bleed

Neurologic
____ Stroke
____ Head Injury
____ Headaches
____ Depression
____ Anxiety
____ Chronic pain
____ Bell's Palsy
____ Herpes/Cold sores
____ Nerve compression

Pulmonary
____ Asthma
____ Hay Fever
____ Bronchitis
____ Pneumonia
____ COPD
____ Restrictive lung disease
____ Sleep Apnea

Endocrine/Heme
____ Hypothyroidism
____ Hyperthyroidism
____ Diabetes
____ Autoimmune disease
____ Sickle Cell / Trait
____ Anemia
____ HIV+

Musculoskeletal
____ Arthritis / DJD
____ Rheumatoid arthritis
____ Spine – herniated disc
____ Spine – arthritis/DJD
____ Paralysis
____ Fibromyalgia
____ Broken bones

Head and Neck
____ Dry Eyes
____ Glaucoma

Cancer
Type _____
Chemotherapy: Yes No Radiation: Yes No

Other Illnesses Not Listed: _____

Surgical History

Year **Operation**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had a problem with anesthesia? Yes No
If yes, what occurred? _____
Has a family member or relative had a problem with anesthesia? Yes No What? _____
Have you been told you need to take an antibiotic before surgery? Yes No Why? _____
Have you have rheumatic fever? Yes No
Do you have any metal implanted? Yes No If yes, where? _____

Allergies to Medications

_____
_____

Medications; include dosage, directions for use, purpose of medicine

_____
_____
_____
_____
_____
_____

Pharmacy Name _____
Pharmacy Telephone # _____

Herbal supplements and vitamins; include dosage and directions for use:

_____
_____
_____
_____

Social History

Please circle: Married Partner Single Divorced Separated Widowed
Children? Yes No
Occupation? _____
If medical problem is work related please explain: _____
_____
_____
_____
Do you currently smoke? If yes, how much and how long have you smoked? Yes No
_____

If you quit smoking; how long ago? _____
Do you drink alcohol? Yes No
How often do you drink? _____
Do you use street drugs or illegal drugs? Yes No What? _____
Have you ever been treated for drug use? Yes No
Have you ever been treated for alcohol use? Yes No

Family History

Illness **What/Who**
Heart disease _____
Vascular disease _____
Lung disease _____
Diabetes _____
Cancer _____
Bleeding problems _____
Blood clotting problems _____
Other _____

System Review check those that apply

___ Chest pains	___ Easily bruise	___ Insomnia	___ Numbness/Tingling
___ Abnormal heart beats	___ Heartburn	___ Dizziness	___ Coordination Prob.
___ Swelling of legs/feet	___ Diarrhea	___ Hearing loss	___ Weakness
___ Leg cramps w/ walking	___ Constipation	___ Ringing in ears	___ Joint stiffness
___ Sinus problems	___ Urine incontinence	___ Vision loss	___ Fever
___ Shortness of breath	___ Stool incontinence	___ Muscle pain	___ Blood transfusion
___ Coughing	___ Weight gain ___lbs	___ Back pain	___ Poor healing
___ Fainting/blackouts	___ Weight loss ___lbs	___ Neck pain	___ Ugly scarring

General Information Sheet

(Please Print Clearly) **Today's Date** _____

PATIENT:
Name _____
What would you like to be called _____
Address _____City _____ State ___ Zip _____
DOB _____ Age _____ Male _____ Female _____ Ht _____ Wt _____
Home phone _____Work phone _____SS# _____-_____-_____
Cell phone _____ Email address _____
Employer _____ Occupation _____
Employer's address _____
Spouse's Name _____ SS# _____-_____-_____
DOB _____ Spouse's Employer _____
Employer's Address _____
Phone number _____ Occupation _____

RESPONSIBLE PARTY (if minor under the age of 18):
Name _____ Relation to Patient _____
DOB _____ SS# _____-_____-_____ Insured ID# _____ GP#_____
Home address _____
Home phone _____Work phone _____
Employer name _____ Address _____

EMERGENCY CONTACT: (someone not living in your home with different number)
Name _____ Relation to Patient _____
Phone number _____

REFERRAL INFORMATION: (please tell us who referred you to our practice):
Physician Referral _____ Phone number _____
Physician address _____
Patient Referral _____
Other _____
Reason for Visit Today:
_____
Due to Injury? Y or N Date of Injury _____ On the job injury? _____ Auto Accident _____

INSURANCE INFORMATION:
Primary Insurance Information
Name of Insured Party/Policy Holder _____ Relation to Patient _____
DOB Insured Party _____ SS# Insured Party _____-_____-_____
Insured ID#/Policy # _____ Grp# _____
Name of Primary Insurance Carrier _____ Phone Number _____
Mailing Address _____
Employer Name _____
Employer Address _____

Secondary Insurance Information
Name of Insured Party/Policy Holder _____ Relation to Patient _____
DOB Insured Party _____ SS# Insured Party _____-_____-_____
Insured ID#/Policy # _____ Grp# _____
Name of Secondary Insurance Carrier _____ Phone Number _____
Mailing Address _____
Employer Name _____
Employer Address _____

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OFFICE POLICIES

-Our office hours are Monday through Friday, 9:00 am to 5:00 pm. We close the office from 12:00 to 1:00 for lunch. If you have an emergency, you can call 911 or go to the nearest emergency room.
-On occasion, our office may close early for meetings, seminars, training, etc. In this case, you may leave a message with the answering service and your call will be answered the following business day.
-All telephone calls will be answered as soon as possible, although every effort will be made to return calls within 24 hours. If you feel need immediate attention, please notify the receptionist when you are calling the office. Calls are returned in the order they are received and in order of urgency.
-It is our goal to schedule everyone as soon as possible for diagnostic testing, physical therapy, and surgeries. However, all are subject to insurance approval. Unfortunately, this process takes time. Please be aware that scheduling can take up to 2 weeks.
-Prescription refills will be called in as soon as possible. If you are taking prescription medication previously prescribed by another physician, you will need to contact the prescribing doctor for the refill.
-All forms to be completed by our office, i.e. Disability, Workman's Comp, etc., must be given to our office with ample time to complete. Please allow 10 business days to complete forms. Please keep in mind that there are charges for completion of the forms.
-On occasion, the physician may be called away from the office for an emergency. This is the nature of a surgeon's practice. In this case, your appointment will have to be rescheduled. We will make every effort to notify you as soon as possible when this situation arises.
-Please contact us if you will be late or will not be able to make your scheduled appointment. If you arrive 15 minutes late to your appointment you will be rescheduled.

-A return check fee of $30.00 will be collected with any insufficient notice of returned check deposited.

I have read and understand the above office policies.

Signature Date

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PHOTOGRAPHIC RELEASE AND CONSENT

I,_____ agree that Patty Young M.D. or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Patty Young M.D.

Patient Signature		Date

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize (
) M.D. to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed:

	My surgeon's office patient education materials
	MY SURGEON'S FILE OF PRE- AND POSTOPERATIVE PATIENT PHOTOGRAPHS AVAILABLE TO PROSPECTIVE PATIENTS FOR VIEWING IN THE OFFICE
	Newspaper and magazine articles in which my surgeon participates
	Television programs in which my surgeon participates
	My surgeon's personal web site or web page
	Lectures and multimedia presentations given by my surgeon for the general public

I also authorize my plastic surgeon's professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

	Patient education brochures available for purchase
	EDUCATIONAL VIDEO TAPES AVAILABLE FOR PURCHASE
	Lectures and slide presentations available for purchase
	Television programs about plastic surgery
	Case studies presented on the Society's web site at www.surgery.org

Signature of Patient or Personal Representative		Date
Printed Name of Patient or Personal Representative		Relationship of Personal Representative to the Patient

Signature of Practice Representative

Payment/Insurance Benefits for Surgical Procedures

As a service to you, we will request written pre-determination of surgical benefits from your insurance company before surgery if necessary. We will attempt to determine insurance benefits (if any) for surgical procedures. This process usually takes approximately six to eight weeks. Most insurance companies will respond regarding your coverage and proposed benefits. However, such a response is not a guarantee of payment. The actual claim cannot be submitted to the insurance company initial after the surgery is done. The operative report that accompanies (should the insurance company request) the claim will be used by the insurance companies to determine actual medical necessity, and therefore, their reimbursement. Dr Young would also, like to inform you that she has a financial interest in the Surgery Center at Craig Ranch and the Hospital at Craig Ranch in McKinney, Texas.

If surgery is covered by insurance, the patient's portion of Dr. Young's fees will be collected in full prior to the date of surgery. If you elect to have your surgery prior to receiving a written response from your insurance carrier or prior to obtaining authorization, you will be responsible for paying the entire amount of the surgery.

Sometimes, the insurance carriers will not know exactly how much will (or will not) be reimbursed. Caution should be exercised in making a financial decision based on the information furnished by your carrier. Your insurance policy is a contract between you (or your employer) and the insurance company. This office is not a party to that contract. Most insurance companies have set forth their own fee schedules that may or may not coincide with our fees. If we are a participating physician with your insurance carrier, we have agreed to accept their fee schedule. If the physicians fees do not fall within your insurance company's fee schedule or we are not participating providers, (i.e., the fee is above usual and customary) you will be responsible for the remaining balance after the insurance has completed processing the claim. Even in the event that written approval has been obtained, you will be responsible for payment of any balances not paid, not covered or not processed by your insurance carrier, regardless of the reason for non-payment.

Unfortunately, we are unable to carry account balances for more than 90 days. Some carriers complicate the payment of claims by continuing to ask for information even after it has been furnished. If we have provided all requested information and the carrier continues to "review the claim" and withhold reimbursement, you will be required to assume negotiations at that point. If after the 90 days your insurance company has not settled in full with this office, you will be responsible for immediate payment in full and any necessary follow-up with your carrier.

Additionally, the American Medical Association guidelines provide for post-operative visits at no charge if they are routine in nature during a specified period of time. The "global period" ranges from 0 to 90 days depending on the type of surgery or procedure performed. Following the expiration or the global period, charges will resume for all office visits. Secondarily, if you require treatment during this time period for things that are not routine in nature, there will be a charge.

This office utilizes electronic billing for insurance claims with most of the major insurance carriers. Your signature below indicates that you understand your claims maybe sent electronically and that you have given your consent and authorization.

By your signature below, you confirm that you understand these policies and agree to comply with them.

_____	_____
Signature of Responsible Party	Patient's Name
_____	_____
Signature of Witness	Date

I, _____ give permission for Dr. Patty
(please print)
Young to send via facsimile or mail my medical records to other physicians who request them.

I also authorize medical records including all operative notes, pathology reports, diagnostic testing, x-ray reports with interpretation, progress reports, patient demographics, etc…to be released to:

Patty Young, MD
4104 West 15th Street
Suite 200
Plano, Texas 75093
Fax 972-398-0199
Phone 972-398-1131

Thank you,

_____
Signature of Patient or Legal Guardian

_____
Date

_____
Signature of Witness

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

PATIENT: _____
DOB: _____

I acknowledge that I have reviewed and been offered a copy of The Privacy Practices from the offices of Patty Young M.D.

I want the office of Patty Young MD to either notify me of my appointment via a phone call or mail.

I want to receive email notifications about specials the office is offering monthly.

_____
Email Address

_____
Patient Signature

_____
Date

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Notice of Privacy Practice

Patty K. Young, M.D., P.A.

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 our Privacy Contact, MarChel McDaniel.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare 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 healthcare services.

We are required to abide by the terms of this Notice of Privacy Practice. 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 Practice by 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.

Uses and Disclosures of Protected Health Information

Your physician will use or disclose your protected health information as described in this Section. 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 healthcare services to you. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected healthcare 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 healthcare and any related services. This includes the coordination or management of your healthcare with a third party that has already obtained your permission to have access to your protected health information. 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 when we have the necessary permission from you to disclose your protected health information. 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 healthcare provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

Payment. Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare 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 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, marketing and fundraising activities and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may us e 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, transcription services) 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 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. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request these materials not be sent 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 indicate in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to 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 you protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, 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 healthcare will be disclosed.

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 healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary, if we determine 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 healthcare.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

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

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include the following:

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 Disease: 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 healthcare 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 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 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 process 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: 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.

IV. Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information if we believe 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 fo 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.

Worker's 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 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 Section 164.500 et. seq.

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 use for making decisions about you.

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 Contact if you have any 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 Practice. 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 may request a restriction by first contacting our Privacy Contact, MarChel McDaniel, by phone at (972) 398-1131, for further information and by putting your specific request in writing.

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 Contact at our office.

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 a s 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 Contact to determine if you have question 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 the Notice of Privacy

Practice. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions, and limitations. All such requests must be made in writing and directed to our privacy contact, MarChel McDaniel.

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.

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 fie a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, MarChel McDaniel, at (972) 398-1131, for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.