

James P. Loftin, M.D.

Melissa L. Tompkins, M.D.

Vivek A. Padegal, M.D.

Dallas Location: 9 Medical Parkway, Suite 208, Dallas 75234 (972) 394-2971

Carrollton Location: 4333 N. Josey Ln., Suite 203, Carrollton 75010 (972) 394-2971

Plano Location: 6124 W. Parker Rd., Suite 330, Plano 75093 (972) 378-3272

Dear New Patient;

It is **very important** that you complete the following questionnaire for the appointment you have scheduled on _____ . By answering all of the questions as completely as possible before your appointment, you will save considerable time in the doctor's office. If you do not complete this paperwork prior to your appointment, **please arrive an hour early to do so.**

When you arrive for your appointment, please present a current insurance card to the receptionist. If your insurance plan requires a referral from your primary care provider, please bring it with you. **If no referral is presented, the receptionist will have to re-schedule your appointment.** If you do not know if your insurance plan requires a referral, call the benefits phone number on your insurance card and ask.

If you have a current chest X-Ray, please bring it with you (***Dr. Padegal and Dr. Tompkins require a chest X-Ray within the last two weeks***). If you have had a CT of the chest within the last three years, please bring the films with you. Please expect the initial visit to last at least an hour. Some visits may take longer depending on the number of breathing tests performed. After the initial visit, your appointments will generally be much shorter.

Please call twenty-four hours in advance if you are unable to keep your appointment. Since there are a limited number of new patient appointment times per week, many patients wait one or two months for an appointment. When a new patient does not show up for an appointment or reschedules less than 24 hours in advance, there is not enough time to call a patient who has been waiting for an appointment. Therefore, **due to the high increase in the number of patients not showing up for their scheduled appointment**, if you do not show up for your appointment or reschedule less than 24 hours before your appointment, **we will not be able to reschedule your appointment for a later date and you will need to find another doctor; or, you may schedule an appointment with the doctor after paying a \$95.00 no-show fee.**

If you have any questions, please call the office where you are scheduled. We look forward to your first visit with our caring staff.

Sincerely,

James P. Loftin, MD

Vivek A. Padegal, MD

Melissa L. Tompkins, MD

Kathy Deans, PA-C

James P. Loftin, M.D.

Melissa L. Tompkins, M.D.

Vivek A. Padegal, M.D.

Dallas Office: 9 Medical Parkway, Plaza 4, Suite 208, Dallas

(972)394-2971 FAX (972)492-1261

Carrollton Office: 4333 N. Josey Ln., Plaza 2, Suite 203, Carrollton

(972)394-2971 FAX (972)492-1261

Plano Office: 6124 W. Parker Rd., MOB 3, Suite 330, Plano

(972)378-3272 FAX (972)378-9853

NAME _____

AGE _____

HOME PHONE _____

WORK PHONE _____

APPOINTMENT WITH _____ M.D.

APPOINTMENT DATE _____

PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE.

IF YOU NEED MORE SPACE FOR ANY SECTION, PLEASE USE AN EXTRA PAGE.

IF YOU HAVE ANY PROBLEM WITH THIS FORM PLEASE CALL THE OFFICE.

Name of Address of Referring Physician

Name and Address of Family Physician

Please describe all of the problems that you are currently experiencing which caused you to seek treatment here today.

Do you have any other medical problems? NO _____ YES _____ if YES, list below.

RESPIRATORY

Have you noticed any shortness of breath? NO _____ YES _____

If YES,

How long have you noticed this? _____
_____ when sitting or resting?
_____ when walking slowly?
_____ when walking fast?
_____ only when doing heavy work or physical activity?
_____ when climbing stairs? How many flights? _____

When you breathe, do you notice a wheeze or whistling
In your chest? NO _____ YES _____

How long have you noticed this wheezing?
_____ all my life
_____ over 10 years
_____ over 1 year
_____ just recently

How often does the wheezing occur?
_____ all the time
_____ nearly every day
_____ some every week
_____ some every month
_____ only on rare occasions

When does the wheezing occur?
_____ any time of the year
_____ seasonal (check which) _____ Spring _____ Summer _____ Fall _____ Winter
_____ any time day or night
_____ nighttime only
_____ only when physically active

Do you cough up any sputum or phlegm? NO _____ YES _____

If YES,

When do you cough it up?
_____ any time
_____ yellow or green
_____ brownish
_____ red-streaked (or blood streaked)

How much do you cough up?
_____ small amount- 1 tablespoon/day
_____ moderate amount- 1 tablespoon/day to ½ cup day
_____ a lot- more than ½ cup/day

Do you have a constant or bothersome cough? NO _____ YES _____
 If YES, how long have you had it? _____

Do you have frequent chest colds? NO _____ YES _____
 If YES, how many times per year on average? _____
 And for how many years? _____

Do you cough blood? NO _____ YES _____
 If YES, when was the last time you coughed up blood? _____
 Have you ever had this happen before? NO _____ YES _____

Have you ever had difficulty breathing after taking aspirin? NO _____ YES _____

Have you ever had difficulty breathing after drinking wine? NO _____ YES _____

Do you cough or experience difficulty breathing after exposure
 To strong smells (fumes, smoke, dust, perfumes, Etc.?) NO _____ YES _____

Do you use a feather pillow or a down filled pillow? NO _____ YES _____

Have you been exposed to anyone with tuberculosis? NO _____ YES _____

Have you had a skin test for tuberculosis? NO _____ YES _____
 If YES, when _____ What was the result? NEG _____ POS _____

Do you cough, produce phlegm and/or wheeze when you exercise? NO _____ YES _____

How far can you walk at a normal pace on the level?
 _____ room to room only
 _____ 1 block or less
 _____ 2 to 6 blocks
 _____ unlimited

PAST MEDICAL HISTORY

LIST ALL CONDISTIONS FOR WHICH YOU HAVE RECEIVED MEDICAL TREATMENT.
 LIST ALL HOSPITAL ADMISSIONS AND SURGICAL PROCEDURES.

	CONDITION/SURGERY	DATE	TREATMENT
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

List below **all** medications, eye drops, vitamins, laxatives, etc., that you take regularly or have taken during the **past month**. If name of medication is not known, please find out from your druggist the name or bring the medication with you. Include both prescription and non-prescription agents.

	NAME (IF KNOWN)	PURPOSE FOR WHICH TAKEN	HOW OFTEN? IF DAILY HOW MANY A DAY?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Do you have any drug allergies? NO _____ YES _____ If YES, list below with type of reaction

	MEDICATION OR DRUG	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Estimate that last date that you had the following items:

Complete medical examination	20 ___	Blood sugar check for diabetes.....	20 ___
Eye examination.....	20 ___	Electrocardiogram (EKG).....	20 ___
Blood pressure check.....	20 ___	X-Rays Chest.....	20 ___
Blood count.....	20 ___	Mammogram.....	20 ___
Flu vaccine.....	20 ___	Prostate Test.....	20 ___
Pneumonia vaccine.....	20 ___	Pap Smear.....	20 ___

SOCIAL HISTORY

Are you: Single _____ Married _____ Separated _____
 Divorced _____ Widowed _____ Widower _____

Have you ever used tobacco? NO _____ YES _____

If YES,
 _____ Presently using:
 _____ cigarettes _____ packs a day for _____ years
 _____ other form of tobacco (describe _____) for _____ years
 _____ None for _____ years
 Smoked _____ packs a day for _____ years

How many children do you have? _____

Have you any children with medical problems? NO _____ YES _____ if YES, list below:

Have any of your Grandparents, Uncles, or Aunts died under the age of 65 years? NO ____ YES ____

If YES, list with age and cause of death:

If any of your **BLOOD** relatives have had the following conditions, check and indicate their relationship to you:

_____	Asthma	_____
_____	Chronic Bronchitis	_____
_____	Emphysema	_____
_____	Allergies	_____
_____	Diabetes	_____
_____	Tuberculosis	_____
_____	Heart Disease	_____
_____	High Blood Pressure	_____
_____	Stroke	_____
_____	Cancer	_____
_____	Condition like yours	_____
_____	Blood clots in legs or lungs	_____
_____	Bleeding problems	_____

REVIEW OF SYSTEMS

SKIN

Do you have any skin lesions: NO _____ YES _____
If YES, describe (or give its name if possible) _____

EYES

Do you wear glasses? NO _____ YES _____
When your eyes were last examined? 20 _____
Have you noticed any difficulty with your vision? NO _____ YES _____
If YES, describe _____

EARS

Do you have difficulty hearing? NO _____ YES _____
Do you wear a hearing aid? NO _____ YES _____
Do you have frequent earaches? NO _____ YES _____
Do you have any discharge from your ears? NO _____ YES _____
Do you usually hear annoying buzzing or ringing in your ears? NO _____ YES _____

NOSE AND THROAT

Do you sneeze frequently? NO _____ YES _____
Is your nose continually stuffed or runny? NO _____ YES _____
Do you constantly feel drainage down the back of your throat? NO _____ YES _____
Do you have severe nosebleeds? NO _____ YES _____
Do you have intermittent hoarseness? NO _____ YES _____
Do you have persistent hoarseness? NO _____ YES _____
Has the sound of your voice changed? NO _____ YES _____
Do you often feel a choking sensation or lump in your throat? NO _____ YES _____

CARDIAC

Do you have a heart condition? NO _____ YES _____
If YES, describe _____
Do you have a chest pain with exertion? NO _____ YES _____
If YES, describe _____
Are you aware of an irregular heartbeat? NO _____ YES _____
If YES, describe _____
Do you sleep with 2 or more pillows or with a “wedge”? NO _____ YES _____
If YES, describe _____
Do you wake up at night with a “smothering” feeling? NO _____ YES _____
If YES, describe _____
Do you have swelling of your ankles? NO _____ YES _____
If YES, describe _____
Do you have pain or cramping in your legs when you walk? NO _____ YES _____
If YES, describe _____
Do you bleed easily? NO _____ YES _____
If YES, describe _____

GASTRO-INTESTINAL

Have you noticed any difficulty in swallowing food or water? NO _____ YES _____
If YES, describe _____
Do you have trouble with indigestion or heartburn? NO _____ YES _____
If YES, describe _____
Are you bothered with nausea or vomiting? NO _____ YES _____
If YES, describe _____
Has there been a recent change in your bowel habits? NO _____ YES _____
If YES, describe _____
Do you take OTC antacids? NO _____ YES _____

If YES, describe _____

Do you have a sense of reflux of stomach acid or stomach contents into your esophagus? Or into your throat? NO _____ YES _____

Have you had any bleeding from your rectum or with bowel movements? NO _____ YES _____
If YES, is it bright red blood? _____ How often does it occur? _____

Have you noticed any black or tarry stools? NO _____ YES _____
If YES, how often does it occur? _____

URINARY TRACT

Do you have burning or pain when you urinate? NO _____ YES _____
Do you get up more than once a night to urinate? NO _____ YES _____
Do you have any problem starting to urinate? NO _____ YES _____
Have you ever noticed blood in your urine? NO _____ YES _____

Women: Are you past menopause? NO _____ YES _____
Have you noticed any lumps in your breast? NO _____ YES _____

MUSCULO-SKELETAL

Do you suffer from joint pain or swelling? NO _____ YES _____
Do your muscles/joints frequently feel stiff or sore? NO _____ YES _____
Do you have osteoporosis? NO _____ YES _____

NEUROLOGIC

Do you have frequent or severe headaches? NO _____ YES _____
If YES, describe _____

In the past year have you fainted or lost consciousness? NO _____ YES _____
If YES, describe _____

Have you had any slurring or difficulty with your speech? NO _____ YES _____
If YES, describe _____

Do you have numbness or tingling of your head, arms or legs? NO _____ YES _____
If YES, describe _____

Have you had any weakness of your hands, arms, or legs? NO _____ YES _____
If YES, describe _____

Do you have trouble sleeping? NO _____ YES _____
If YES, describe _____

Do you snore? NO _____ YES _____
Do you have pauses in your breathing while asleep? NO _____ YES _____

Do you have leg cramps or restless legs at night?	NO _____	YES _____
Do you get sleepy in the daytime?	NO _____	YES _____
Do you have difficulty getting up in the morning?	NO _____	YES _____
Do you still feel tired when you get up?	NO _____	YES _____
Do you suffer from insomnia?	NO _____	YES _____
Do you have "sleep paralysis"?	NO _____	YES _____
Do you have vivid dreams as you start to fall asleep?	NO _____	YES _____

WEIGHT

What is your present weight? _____ lbs. What is your usual weight? _____ lbs.
 Has your weight changed in the past year? _____ No _____ Gained _____ Lost _____
 If you have gained or lost more than 10lbs, what do you believe is the reason?

HOBBIES

Please list your hobbies:

TRAVEL

Please list destinations and dates for travel outside the U.S. in the past 3 years:

PETS

Please list all pets (including fish) and indicate if indoor or outdoor:

DIET

Are you on any special diet? NO _____ YES _____
 If YES, describe _____

EXERCISE

Do you exercise? NO _____ YES _____
If YES, describe the type and duration _____ min and
Frequency _____ times per week.

Please bring all X-Rays, medical reports and medications with you to our office. Please list any other information, which you feel may be helpful:

Completed by: _____

All information provided is complete and accurate to the best of my knowledge.

Signed _____ Date _____

Reviewed by _____ Date _____

PATIENT INFORMATION FORM

DATE: _____

PATIENT NAME: _____ **DOB:** _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **SEX:** M F

SOCIAL SECURITY NUMBER: _____ **MARITAL STATUS:** _____

EMPLOYER: _____ **REFERRING DR.:** _____

GUARANTOR NAME: _____ **DOB:** _____

RELATIONSHIP TO PATIENT: _____ **DAYTIME PHONE:** _____

ADDRESS: _____

EMERGENCY CONTACT: _____ **DAYTIME PHONE:** _____

PRIMARY INSURANCE: _____ **POLICY NO.:** _____

GROUP NO.: _____ **INSURED NAME:** _____

PHONE NO.: _____ **PRIM. INS. ADDRESS:** _____

SECONDARY INSURANCE: _____ **POLICY NO.:** _____

GROUP NO.: _____ **INSURED NAME:** _____

PHONE NO.: _____ **SEC. INS. ADDRESS:** _____

BENEFITS ASSIGNMENT AND MEDICAL RECORDS RELEASE

I authorize payment of medical benefits to the treating physician or supplier for these services and all future claims.

Signature of Patient or Guarantor: _____

I authorize the release of any medical information necessary to process this claim and all future claims.

Signature of Patient or Guarantor: _____

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

BASIC POLICY Pay for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

Please check: I have paid my insurance deductible for the calendar year _____ Yes _____ No _____ Don't know

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made on my behalf to the health care professional providing any services furnished me. I authorize any holder of medical information about me to release to the health care professionals' billing staff any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance" is indicated in Item 9 of the HCFA-1500 from or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS I hereby assign all medical and/or surgical benefits to the health care professional providing health services to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I understand that my insurance is a contract between myself and my insurance company. The healthcare professionals' billing staff will file my claim and will work to resolve any problems obtaining payment from my insurance company, but ultimately it is my responsibility to contact my insurance company to resolve any problems. I have read, understood and agree to the above financial policy for payment of professional fees.

The patient is ultimately responsible for all professional fees.

Signature _____ Date _____

James P. Loftin, M.D.

Melissa L. Tompkins, M.D.

Vivek A. Padegal, M.D.

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 it 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. 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 we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. 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 we provide 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 we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

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. Some examples are business associates such as vendors and/or contractors used for billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories, other free standing diagnostic facilities and legal counsel. The physicians require all business associates to appropriately protect the confidentiality of your private health information.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an 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 and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that 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 a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading 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.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations 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 Proceedings 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 a law enforcement official, we may disclose your medical information under limited circumstances provided:

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

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

Workers' Compensation

We may disclose your medical information as required by workers' compensation law.

Inmates

If you are an 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 institution.

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 authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

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

When a research project and its privacy protections have been approved by an 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 person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law

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

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

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.

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

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 the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. 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.

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 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 the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information 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 arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you 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-based fee.

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 the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- **The information wasn't created by this practice or the physicians in this practice.**
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- 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 know have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures 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 an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests 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.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

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

E. 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 U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

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

G. Questions and Contact Person for Requests

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

Barbara Ragsdale
6124 W. Parker Rd.
MOB 3, Suite 330
Plano, TX 75093

This notice is effective September 1, 2009.

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

Description of Personal Representative's Authority