DIGESTIVE
HEALTH CENTER

Specialists who help you feel your best

Steven A. Fein, M.D., FACG
4001 Preston Ave, Suite 125
************************** **Call (713) 946-9513 ∞ Fax (713) 946-7210** ************************

PATIENT INFORMATION – ***Please Print*** Referred by: ___________________________

Last Name _____________________ First Name ___________________ MI _____ __ Date of Birth _____/_____/______

Address ____
Street City State Zip

Primary Phone# ________________ Alternate Phone# _________________Email _______________________________

____ Male ____Female (Check One) ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Life-Partner (Check One)

Social Security# ____-____-______ Driver's License# ________________ State __________ Race/Ethnicity_________

Employer____
Name Street City State Zip

Emergency Contact: ____________________________________ Phone Number ________________________________

Nearest Relative (not living with you)

____
Name Address & Phone Number Relationship

Primary Care or Referring Physician ____
Name Phone Number

INSURANCE INFORMATION – ***A Copy of Your Insurance Card & Driver's License/Photo ID is Required***

Primary Insurance ____ Phone # _______________________________

Policy Holder _____________________________ SS# __________________________ Date of Birth ___/___/______

Secondary Insurance ____ Phone# _________________________________

Policy Holder _____________________________ SS# __________________________ Date of Birth ___/___/______

COMMUNICATION AUTHORIZATION – ***Please Complete***

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact should we need to reach you. Place a √ in the appropriate box(es).

☐ Primary Phone# ☐ Message to return call ☐ Detailed message (results, treatment) ☐ No message ☐ Voice mail ☐ Family member
☐Alternate Phone# ☐ Message to return call ☐ Detailed message (results, treatment) ☐ No message ☐ Voice mail ☐ Family member

<u>RELEASE OF INFORMATION POLICY</u> – *Please Read*

I hereby authorize Digestive Health Center to use and/or disclose my personal health information which identifies me, or which can be reasonably used to identify me, to carry out my treatment, payment and other health care operations. My protected health information may be released to the following individual(s):

Name ________________________________ DOB ___/___/____ Relationship to patient________________________

Name ________________________________ DOB ___/___/____ Relationship to patient________________________

I have been provided the ***Notice of Privacy Policies*** for Digestive Health Center, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and other health care operations. I understand that I have the right to review such "notice" prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Digestive Health Center in writing, but if I revoke my consent, such revocation will not affect any actions that Digestive Health Center took before receiving my revocation.

I understand that Digestive Health Center has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Digestive Health Center restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or other health care operations. I understand that Digestive Health Center does not have to agree to such restrictions, but that once restrictions are agreed to, Digestive Health Center must adhere to such restrictions.

<u>FINANCIAL POLICY</u> – *Please Read*

I acknowledge full financial responsibility for services rendered by Digestive Health Center (*Pasadena Gastroenterology Associates, P.A./Steven A. Fein, M.D.)*, and authorize transfer of all unpaid amounts to me, which include, but is not limited to, **CO-PAYS, DEDUCTIBLES, CO-INSURANCE, PRE-EXISTING/EXCLUDED CONDITIONS, and TERMINATION OF COVERAGE.**

I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default of payment of charges that are my financial responsibility.

<u>ASSIGNMENT OF BENEFITS</u> – *Please Read*

In return for services rendered by Steven A. Fein, M.D. and/or his associates, I hereby irrevocably assign and transfer to Digestive Health Center all right, title, and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents and I are entitled to recover. _______

<u>ACKNOWLEDGEMENT</u> – *Signature Required*

- I acknowledge that I have received the "Notice of Privacy Policies" for Digestive Health Center.
- I hereby authorize Digestive Health Center to release any information requested by the above named insurance company or companies or their respective representatives for payment of services rendered.
- I understand that I am financially responsible to the physician for any charges incurred by myself and/or my dependents.

I have read and understand the "Release of Information Policy" and the "Financial Policy" established by Digestive Health Center. I further acknowledge that I accept the terms outlined in each of the policies. I understand that, while this consent is voluntary, if I refuse to sign this consent, Digestive Health Center can refuse to treat me.

____ ____________________

Signature of Patient (or Patient's Representative) Date

____ _________________________________

Printed Name of Patient (or Patient's Representative) Representative's Relationship to Patient (if applicable)

Digestive Health Center

New Patient Gastroenterology History Form

First Name __________________________ **MI** ____ **Last** ________________________________ **MR#** ________

SS# _________________________ **Date of Birth** __________________ **Male Female Marital Status** ________

Occupation _________________________ **Referring Physician** ____

CHIEF COMPLAINT & PRESENT ILLNESS

Today's Date ________________ **List All Symptoms** ____

____

If Symptom(s) Includes Pain, Please Circle All That Best Describe Your Pain:

Aching Burning Continuous Cramping Deep Dull Gnawing Gradual Intermittent Mild

Moderate Periodic Sharp Shifting Stabbing Sudden Superficial Other __________________________

Duration _____ **Years** _____ **Months** _____ **Weeks** _____ **Days** ____ **Other** ___________________________

Location of pain________________________________ **If Experiencing Abdominal Pain *(please specify location)***

RT Upper RT Lower LT Upper LT Lower Middle Other ____

Date Symptom(s) Began _________________ **Frequency of Symptom(s)** __ **x Per Day** __ **x Per Week**

__ **x Per Month** ___ **x Per Year Constant Intermittent Occasional Rare Recurrent Other** _________________

Intensity of Symptoms Excruciating Improving Mild Moderate Severe Other ________________________

How Did Symptom(s) Start ____

How Did Symptom(s) Progress ____

What Brings It On___________________________________ **What Makes It Worse** ________________________

What Relieves It _______________________________ **Associated Symptom(s)** ____________________________

____

How Often Do You Take Antibiotics Never _____ **times per year Other**______________________________

Comments ____

____

____

MEDICATIONS

List All Medications You Are Currently Taking. Include ALL Medications Even Over-The-Counter Products.

Drug Name (Generic/Brand)	Strength/Dosage	Frequency	Reason for Medication

ALLERGIES

List your allergies including any medications that caused an allergic reaction.

List All Allergies	Describe Allergic Reaction

PAST MEDICAL HISTORY

Please provide a complete history including all illnesses, injuries, hospitalizations and operations

List All Surgeries	Date	Hospital	Treatment	Physician	Response to Treatment

MEDICAL PROBLEMS

Please list any past or current medical problems.

FAMILY HISTORY

Please list all Blood Relatives with their current health status and any illnesses they have had or have.

List Blood Relatives	Current Health Status	Age, *If Living*	Age, *At Death*	Cause of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

SOCIAL HISTORY

Please check all that apply.

Mental Work: Omit Light Moderate Heavy Hours Per Day: _____

Physical Work: Omit Light Moderate Heavy Hours Per Day: _____

Exercise: Omit Light Moderate Heavy Hours Per Day: _____

Types of Exercise ____

Alcohol: Omit Never Beer(s) __ per week Liquor __ per week Wine __ per week How many years ____

Smoking: Omit Never Current Previous Packs per day ___ How many years _____

Caffeine: Omit None Cups per day ___ How many years _____ Other ________________________

Aspirin: Omit None Quantity per day ___ How many years _____ Other _______________________

Nutritional Information: Low Sodium Diet Diabetic Diet Low Fat Diet Vegetarian Diet Low Cholesterol Diet

Other _____________________________

Miscellaneous Drugs: Amphetamines Antacids Cocaine Diet Pills Laxatives Marijuana NutraSweet

Pain Pills Saccharin Sleeping Pills Vitamins Other ___________________________

First Name __________________________ *Middle* ________________ *Last* _____________________________

REVIEW OF SYMPTOMS

Check only the ones you have NOW or have had RECENTLY. Check NONE when applicable

GENERAL SYMPTOMS
- ❑ Chills
- ❑ Fever
- ❑ Night Sweats
- ❑ Feeling tired or poorly (malaise)
- ❑ Feelings of weakness

SKIN SYMPTOMS
- ❑ Skin lesions
- ❑ Rashes
- ❑ Dry Skin
- ❑ Other Skin related symptoms _________

HEAD SYMPTOMS
- ❑ Headache
- ❑ Facial Pain
- ❑ Sinus Pain
- ❑ Other Head related symptoms _______

NECK SYMPTOMS
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Lump or swelling in the neck
- ❑ Enlargement under Adam's apple
- ❑ Muscle aches in the neck or shoulder
- ❑ Other Neck related symptoms

BREASTS SYMPTOMS
- ❑ Breast Pain
- ❑ Nipple Discharge
- ❑ Breast lump
- ❑ Other Breast related symptoms

OTOLARYNGEAL SYMPTOMS (ENT)
- ❑ Hearing Loss
- ❑ Ringing in the Ears
- ❑ Discharge from Ears
- ❑ Ear Ache
- ❑ Itching of the Ears
- ❑ Dizziness
- ❑ Lightheadedness
- ❑ Sneezing
- ❑ Nasal Drip or Drainage
- ❑ Nasal Passage Blockage
- ❑ Nasal Discharge
- ❑ Mouth Dryness
- ❑ Mouth Sores
- ❑ Bleeding Gums
- ❑ Tooth Pain
- ❑ Bad Breath
- ❑ Peculiar Tastes, unrelated to food
- ❑ Sense of Taste Decreased
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Throat Pain
- ❑ Choking
- ❑ Other Otolaryngeal related symptoms _________________

EYES SYMPTOMS
- ❑ Blurry Vision
- ❑ Red Eyes
- ❑ Eye Pain Burning
- ❑ Swelling around Eyes
- ❑ Eye Pain
- ❑ Dry Eyes
- ❑ Watering discharge from eyes
- ❑ Other Eye related symptoms _________________

PULMONARY SYMPTOMS
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Coughing up Blood
- ❑ Wheezing
- ❑ Coughing up Phlegm
- ❑ Feeling Congested in the Chest
- ❑ Other Pulmonary related symptoms ________________

CARDIOVASCULAR SYMPTOMS
- ❑ Chest Pain and Discomfort
- ❑ Fast Heart Rate
- ❑ Palpitations
- ❑ Cold Hands and Feet
- ❑ Hands and Feet are Blue
- ❑ Regional soft tissue swelling both upper extremities
- ❑ Regional soft tissue swelling both lower extremities
- ❑ Pain in legs/Blue extremities
- ❑ Other Cardiovascular related symptoms _________________________________

BLOOD SYMPTOMS
- ❑ Easy Bleeding
- ❑ Swollen Glands in Neck
- ❑ Swollen Glands in Neck/Painful
- ❑ Easy Bruising Tendency
- ❑ Prolonged Bleeding
- ❑ Taking Blood Thinners
- ❑ Taking Aspirin
- ❑ Recent change in dosage of Anticoagulant Medications
- ❑ Other Blood related symptoms ____________________________

GASTROINTESTINAL SYMPTOMS
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Bloating
- ❑ Belching
- ❑ Heartburn
- ❑ Change in Bowel Habits
- ❑ Increase BM Frequency
- ❑ Decrease BM Frequency
- ❑ Constipation
- ❑ Diarrhea
- ❑ Rectal Pain
- ❑ Flatus (Gas)
- ❑ Change in Appetite
- ❑ Black or Bloody Stools
- ❑ Difficulty Swallowing
- ❑ Other Gastrointestinal related symptoms __________________

GENITOURINARY SYMPTOMS
- ❑ Feelings of Urinary Urgency
- ❑ Urinary Incontinence w/o Sensory Awareness
- ❑ Pain in Flank
- ❑ Increased Urinary Frequency
- ❑ Burning Sensation
- ❑ Unable to Restrain Urination at Night While Sleeping
- ❑ Hematuria (Blood in Urine)
- ❑ Painful urination (Dysuria)
- ❑ Genital Lesion
- ❑ Abnormal Urethral Discharge
- ❑ Other Genitourinary related symptoms ______________________________

MUSCULOSKELETAL SYMPTOMS
- ❑ Joint Pain, localized
- ❑ Joint Stiffness, localized
- ❑ Muscle Aches
- ❑ Joint Swelling, localized
- ❑ Muscle Cramps
- ❑ Involuntary Movements, Muscle Twitches, (Tics)
- ❑ Back Pain
- ❑ Other Musculoskeletal related symptoms _______________________

NEUROLOGICAL SYMPTOMS
- ❑ Vertigo
- ❑ Numbness (Hypesthesia)
- ❑ Weak Hand Grip
- ❑ Fainting (Syncope)
- ❑ Motor Disturbances
- ❑ Sensory Disturbances
- ❑ Memory Lapses and Loss
- ❑ Decreased Concentrating Ability
- ❑ Confused and Disoriented
- ❑ Shuffling Walking
- ❑ Convulsions
- ❑ Other Neurological related symptoms ______________________________

PSYCHOLOGICAL SYMPTOMS
- ❑ Sleep Disturbances
- ❑ Anxiety
- ❑ Depression
- ❑ Highly Irritable
- ❑ Thinking About Suicide
- ❑ Hallucinations
- ❑ Anxiety Attacks
- ❑ Libido Has Changed
- ❑ Other Psychological related symptoms __________________________________

ENDOCRINE SYMPTOMS
- ❑ Excessive Sweating
- ❑ Excessive Thirst (Polydypsia)
- ❑ Recent Weight Loss (_____ lbs)
- ❑ Recent Weight Gain (_____ lbs)
- ❑ Temperature Intolerance to Heat (consistent)
- ❑ Temperature Intolerance Alternately too Hot and too Cold
- ❑ Other Endocrine related symptoms ____

Digestive Health Center Financial Policy

This is an agreement between Digestive Health Center/Steven A. Fein, M.D., as creditor and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "ours" refer to Digestive Health Center/Steven A. Fein, M.D.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements and Payments: If you have a balance on your account, you will be sent a monthly statement. Unless we approve other arrangements, your balance is due and payable upon receipt. After 30 days, the account balance is considered past due and a 1.5% finance charge will automatically be added to your next statement. Collection action will be initiated if your balance is not paid within 30 days. After 120 days, your account will be forwarded to a collection agency.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required Payments: Any co-payments, deductibles, coinsurance must be paid at the time of service. This is required by your insurance.

Payment if you have no insurance: You may choose to pay with cash, check, or credit card on the day that treatment is rendered.

NSF Checks: A returned check fee of $30 will be charged to your account when a payment made by check to our office, is not honored by the bank. The payment will be reversed from your account which may result in additional fees added to your account.

No Shows: If you are unable to keep a scheduled appointment, you must contact the office via telephone at least 24 hours in advance. If you fail to notify the office of your cancellation within the time stated above, and miss your scheduled appointment, a no show fee will be applied to your account.

For office visits a $25.00 no show fee will be charged.

For procedures, a $50.00 no show fee will be charged.

For infusions, a $75.00 no show fee will be charged.

Payment options if you have insurance:

1. You will be required to pay co-pays, unmet deductibles, and coinsurance, according to your benefits and our contract with your insurance company *before services are rendered.* This is payable by cash, check, or credit card.

2. For procedures: Your insurance will be called prior to any scheduled procedure. If it was not discussed at the time of your visit, our staff will contact you within 72 hours of your procedure to discuss your benefits and notify you of the amount you will need to pay prior to your procedure. We will make every effort to estimate as closely as possible the amount due from you according to our contract with your insurance. The exact amount due from you cannot be guaranteed until our claim is processed by your insurance company.

***Please Note: Our office collects payment for your portion of the physician's charges only, charges for the out-patient facility are billed separately and questions regarding their fees and pre-payment policies should be addressed to them.**

Insurance: Insurance is a contract between you and your insurance company. An insurance card must be made available to us before you are seen as a patient. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility and allowed amounts. You are responsible for any portion of our charges not paid by insurance less the amount written off due to a contract we may have with your insurance company. Should there be a *pre-existing* clause in your coverage, which results in our claim not being paid, you will be responsible for payment of all amounts denied by insurance. If your insurance requires a referral or authorization, you are responsible for obtaining it. Failure to obtain the referral or authorization prior to your visit may result in denial of payment or reduced payment from your insurance company.

Medicare Recipients If you are enrolled in a ***Medicare Advantage*** plan, which replaces your traditional Medicare coverage, it is your responsibility to notify our office and provide the correct information prior to your treatment.

The physician's expertise is in treating your medical condition; therefore, any questions or concerns regarding financial matters such as charges, billing, refunds, etc. should be addressed to our billing staff and/or the Practice Administrator. Your cooperation in this matter is appreciated.

Patient's Signature Date

Witness Date

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Digestive Health Center

4001 Preston Avenue Ste. 125
Pasadena, TX 77505

Please note that we will not ask you why you are requesting alternative communications. Also, we may be unable to agree to accommodate your request (i.e. it is unreasonable, we do not have the technology, in an emergency). If we agree to your request, we will follow the instructions stated below until such time as you instruct us otherwise in writing. A signed, date copy of this Request shall be as effective as the original.

COMPLETE AS APPLICABLE:

1. This request pertains to the records of ____.

2. I am requesting the following alternative communications: *(circle one)*

Send appointment reminders in closed envelopes rather than by postcards	yes	no
Contact me by telephone to remind me of appointments	yes	no
Send information to my home address	yes	no
Contact me at my home telephone number	yes	no
Fax my information to anyone	yes	no
Email my information to anyone	yes	no
Other____		

3. Send all written communications only to the following address:

____

____

4. During business hours, contact me by telephone only at the following phone number(s):

____

5. Please communicate with me only by: ____

6. Please communicate with me only at the following address:

____

____

7. Additional request(s): ____

8. If Practice agrees to the requests for alternative communications stated above, payment to Practice will be made under the following arrangement:

By Patient: ____ __________________
Print name Sign Date
Or

By Patient's Representative ____ __________________
Print name Sign Date

Describe authority: ____

OFFICE USE ONLY

Describe what alternative communications were denied this ______ day of _____________, 20____

____

Describe what alternative communications were accepted this ______ day of ___________, 20____

____

Authorization for Release of Information
Digestive Health SmartBrief

PATIENT NAME: ____

E-MAIL ADDRESS:

*Please print neatly in **BLOCK CAPITALS**, such as "MSMITH99@EMAIL.COM"*

PHYSICIAN:

Steven A. Fein, M.D.	Pasadena, Texas
Physician Name	*City and State*

I hereby request and authorize my physician to release and disclose my name, my e-mail address, and the name of my physician to SmartBrief, Inc., the publisher of *Digestive Health SmartBrief*.

This disclosure is made for the purpose of subscribing me to *Digestive Health SmartBrief*.

About *Digestive Health SmartBrief*:

- *Digestive Health SmartBrief* is a free, e-mail service containing news and information about digestive health. Subscribers receive the newsletter twice each week.
- *Digestive Health SmartBrief* is provided by the American College of Gastroenterology for the patients of its member physicians.
- *Digestive Health SmartBrief* contains advertising and sponsorships from companies who wish to communicate with the digestive health community. No revenue or any other form of compensation is paid to the member doctors of ACG in conjunction with this service.

My rights:

This authorization may be revoked at any time by writing to my physician unless action has already been taken in reliance on this authorization. This authorization expires once my physician has transferred my information described above to SmartBrief, Inc.

I understand that, once subscribed to *Digestive Health SmartBrief*, I may unsubscribe at any time by using the "Unsubscribe" feature available in the "Subscriber Tools" section of every newsletter.

I understand that my physician may not condition treatment on whether I sign this authorization.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient and no longer protected by federal HIPAA privacy regulations. SmartBrief's privacy policy is available for review on its website: www.smartbrief.com

Signature: ____ **Date:** ________________________

This form is for use of the individual subscribing to the newsletter. If you are the personal representative of someone wishing to subscribe, please refer to www.digestivehealthsmartbrief.com for more information.

For Practice Use:

Maintain this authorization in the patient's file. Three methods for registering a patient:

1. Register patient online at **http://www.digestivehealthsmartbrief.com**
2. Fax copy of this authorization with cover page to Gastro Support at (202) 737-7577.
3. Mail copy to Gastro Support, SmartBrief, Inc., 1100 H St., NW, Suite 1100, Washington

For options 2 and 3, please ensure legibility of patient information before sending.

NOTICE OF PRIVACY POLICIES
FOR
PASADENA GASTROENTEROLOGY ASSOCIATES, P.A.
DIGESTIVE HEALTH CENTER

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.

At **Digestive Health Center**, we are committed to treating and using protected health information (PHI) about you responsibly. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Understanding Your Health Record/Information

Each time you visit **Digestive Health Center**; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of **Digestive Health Center,** the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Digestive Health Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,

- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Faxing and Emailing Rule

When you request us to fax or email your PHI as an alternative communication and we agree to do so, we may fax or email super-confidential information; we will not use fax or email for emergency communication without knowing that the recipient is expecting the message; have only our privacy officer or treating doctor fax or email your PHI; have our privacy officer confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole acce3ss to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message.

Inactive Patient Records

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate agreement prohibiting re-disclosure if necessary).

Collections and Marketing

If we use or disclose your PHI for marketing (i.e. communications that encourage recipients to purchase or use a product or service) or collections purposes, we will do so only in accordance with the law.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post these changes in our office.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact one of the practice's Privacy Officers at (713) 946-9513.

If you believe your privacy rights have been violated, you can file a complaint with one of the practice's Privacy Officers, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

Risk Management: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification**:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family**:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

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 your 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.

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

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

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

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.

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.

***Organ Procurement Organizations*:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Marketing*:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

***Food and Drug Administration (FDA)*:** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
***Workers Compensation*:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

***Public Health*:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
***Correctional Institution*:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

***Law Enforcement*:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

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.

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

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

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

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

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.