Comprehensive Orthopaedics & Rehabilitation

Sacheen H. Mehta, M.D.
Orthopaedic Surgery, Board-Certified
Sports Medicine, Board-Certified

Virendra C. Patel, M.D.
Orthopaedic Surgery, Board-Certified

Sai Madhavapeddi, M.D.
Primary Care Sports Medicine
Board-Certified

Harris Syed, M.D.
Primary Care Sports Medicine
Board-Certified

PATIENT'S LAST NAME: _____ **FIRST NAME:** _____ **SEX:**___

Date of Birth: _____/____/_____ Address: _____

Social Security: _____ - ____ - _____ _____

CONTACT INFORMATION AND PERMISSIONS:

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Mobile Phone: (_____) _____-_____ Email Address: _____

How may we contact you with confidential medical information? (Circle all that apply)

HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Where may we leave a message with confidential medical information? (Circle all that apply)

HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Who else may we speak to regarding confidential medical information?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MARITAL STATUS: (circle one) Married / Single / Divorced / Separated / Widowed / Partner

INJURY INFORMATION: Car Accident: YES / NO On the Job Injury: YES / NO

OTHER CONTACTS:

Emergency Contact:

Name: _____ Relationship: _____ Phone: (____) _____-_____

Financial Guarantor: (Write 'Self' if applicable)

Name: _____

Date of Birth: _____/____/_____ Address: _____

Social Security: _____ - ____ - _____ _____

INSURANCE INFORMATION:

Primary Insurance: _____ ID#_____ Group #: _____

Policy Holder's Name:_____ DOB:___/_____/_____SS#____-_____-_____

Policy Holder's Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify:_____)

Secondary Insurance:_____ ID#: _____Group #:_____

Policy Holder's Name: _____ DOB: ____/____/_____ SS#____-_____-_____

Policy Holder's Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify:_____)

PREFERRED PHARMACY:

Pharmacy Name: _____ **Address:** _____ **Phone:** _____

Payment is required at the time services are rendered We wish to notify you that Dr. Sacheen H. Mehta has ownership/interest in Comprehensive Orthopaedics & Rehabilitation, P.A., Baylor Scott & White Surgicare North Dallas, and Methodist McKinney Hospital and shares in the profits in part from payments made by patients who maybe referred to these facilities. You are under no obligation to use these facilities.

I authorize payment of medical benefits by my insurance policy to Comprehensive Orthopaedics & Rehabilitation, P.A. I understand that I am responsible for the balance on the account regardless of my insurance policy. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as original. I hereby authorize said assignee to release all information necessary to secure payment. I authorize Comprehensive Orthopaedics & Rehabilitation, P.A. and its affiliated healthcare providers to treat me.

Patient Signature: X_____ **DATE:** _____

1120 W. Campbell Road, Suite #109
Richardson, Texas 75080-2978

Phone: (214) 575-2663
Fax: (214) 575-2664

www.comprehensiveortho.com

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PATIENT'S LAST NAME: _____ FIRST NAME: _____ AGE: ____

Primary Care Physician: _____ Who Referred You to Us: _____

MAIN PROBLEM: Circle One – **RIGHT / LEFT / BOTH / Not Applicable**

List Body Area: _____

HISTORY OF PRESENT ILLNESS:

Date of Injury or Onset: _____ Car Accident: YES / NO On the Job Injury: YES / NO

Describe how the problem began: _____

_____

Describe the current pain/problem as specifically as possible (**Character of pain** – burning, aching, sharp, dull, **Timing** – constant, intermittent, sudden, gradual, etc, **Associated symptoms** – numbness, spasm, swelling, etc):

_____

_____

Please grade the severity of the pain from 1 to 10 (10 is the worst pain you have ever felt) _____

What makes the problem worse: _____

_____

What makes it better: _____

List all previous treatments: (e.g. Braces, Casts, Physical Therapy, Medications, Injections, Surgery, etc.)

_____

_____

List any previous treating physicians and their specialties: _____

Have you ever had this problem before (Please describe the circumstances): _____

_____

WORK HISTORY:

Are You Currently Employed: YES / NO Are you Currently Able to Work: YES / NO / LIGHT DUTY

Job Title: _____ Employer: _____

Specific Job Duties: _____

How Much Work Have You Missed As a Result of this Problem: _____

Patient Signature: X_____ **DATE:** _____

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Do not leave any blanks – write "None" for each question if applicable.

PAST MEDICAL HISTORY: (List all acute and chronic medical conditions/problems)

PAST SURGICAL HISTORY: (List all surgeries and procedures, dates, and the physician who performed it)

Surgery/Procedure	Date	Physician	Surgery/Procedure	Date	Physician

ALLERGIES: (List all medication allergies and the type of reaction - i.e. rash, swelling, itching, etc.)

Medication	Reaction	Medication	Reaction

MEDICATIONS: (List all medications you are currently taking and dosages)

Medication	Dose	Frequency	Medication	Dose	Frequency

SOCIAL HISTORY:

Have you used tobacco products: YES / NO Type: _____ Quantity: _____

Do you consume alcohol: YES / NO Amount: _____ Frequency: _____

Have you used illegal drugs: YES / NO Type: _____ Quantity: _____

Could you be pregnant (females): YES / NO If no, how do you know: _____

FAMILY HISTORY: (List any medical problems that run in your family and how he/she is related to you)

_____

REVIEW OF SYSTEMS: (Do YOU have any OTHER symptoms or medical problems)

☐Constitutional:	fever/chills	night sweats	weight gain	weight loss	exercise intolerance	loss of appetite
☐Eyes:	dry eyes	eye irritation	vision change	vision loss	eye discharge	floaters
☐Ears/Nose:	difficulty hearing	ear pain	frequent nosebleeds	nose/sinus problems	poor balance	dizziness
☐Mouth/Throat:	sore throat	bleeding gums	snoring	dry mouth	tooth infection	gum infection
☐Cardiovascular:	chest pain on exertion	arm pain on exertion	shortness of breath when walking		shortness of breath while lying down	
	palpitations	heart murmur	light-headed on standing		excessive sweating	leg swelling
☐Respiratory:	cough	wheezing	shortness of breath	coughing up blood	sleep apnea	rapid breathing
☐Gastrointestinal:	abdominal pain	vomiting	loss of bowel	black/tarry stools	diarrhea	vomiting blood
☐Genitourinary:	loss of urine control	difficulty urinating	urinary frequency	hematuria	incomplete emptying	painful urination
☐Musculoskeletal:	muscle aches	muscle weakness	arthralgia/joint pain	back pain	swelling in arms/legs	>4 painful joints
☐Skin:	abnormal mole	jaundice	rash	itching	dry skin	growths/lesions
☐Neurologic:	loss of consciousness	weakness	numbness	seizures	dizziness	tremors
	frequent headaches	restless legs	tingling	memory loss	difficulty sleeping	difficulty walking
☐Psychiatric:	depression	sleep disturbances	restless sleep	feeling unsafe	alcohol abuse	drug abuse
☐Endocrine:	fatigue	increased thirst	hair loss	increased hair growth	cold intolerance	mood swings
☐Blood/Lymph:	swollen glands	easy bruising	blood clot leg-DVT	blood clot lung-PE	clotting disorder	bleeding disorder
☐Allegy/Immune:	runny nose	sinus pressure	itching	hives	frequent sneezing	joint stiffness

Patient Signature: X _____ **DATE:** _____

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Patient's Name: _____

Medication Policy

1. Our doctor must see you prior to writing any new prescription.
2. No controlled medication will be prescribed over the phone, out of state, after hours or over the weekend.
3. If you have not seen the doctor in the last 3 months and need a refill, you will need to make an appointment first.
4. Prescriptions are sent electronically so it is very important we have the correct pharmacy for you. It is your responsibility to update your pharmacy with our office prior to prescriptions being sent.
5. All medication refills require 48 hours' notice.
6. Written prescriptions are given only when necessary. We are not responsible if you lose your paper prescription and we will not write a replacement prescription.

Initials:_____

Disability Forms and Medical Records

1. Please note there is a $25.00 charge for completing disability forms and $10.00 for medical records.
2. Please allow at least 48 hours for disability form requested and 2 weeks for medical records request.

Initials:_____

Physical Therapy Patients: No Show and Late Appointment Policy

1. Our office requires a **24 HOUR NOTICE** for cancelled appointments.
2. If you are more than 15 minutes late, your appointment will be rescheduled.
3. Please note there is a $25.00 "no show" fee. This charge is billed to the patient, not the insurance company.

Initials:_____

_____ _____

Guarantor / Patient Signature **Date**

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Assignment of Benefits

I agree to pay Comprehensive Orthopaedics & Rehabilitation for all charges and expenses incurred. I understand and agree that I am responsible for the total charges for services rendered, regardless of any assignment of benefits provided. I further agree that the amounts charged are due upon request and are the usual and customary rates for the geographic area for the services. In consideration of services rendered, I hereby irrevocably assign and transfer to Comprehensive Orthopaedics & Rehabilitation for myself and my "dependent," if applicable, all rights, title and interest in the benefits payable for services rendered which are provided in any insurance policy(ies) or group health plans under which we are insured or provided coverage for health benefits. This irrevocable assignment and transfer shall be for the purpose of granting Comprehensive Orthopaedics & Rehabilitation an independent right of recovery based upon their pursuit of my rights under such policies or group health plans. I hereby appoint Comprehensive Orthopaedics & Rehabilitation as my duly authorized representative(s) and attorney-in-fact to act on our behalf, to seek payment of my benefit claims and pursue my rights to medical coverage and the benefits that flow from such coverage, to file appeals related to such claims and to request documents relevant to such claims as permitted under the claim procedure regulations under section 503 of ERISA and in accordance with 29 CFR § 2560.503-1(b)(4) and direct and authorize any payor to communicate with such authorized representative(s) with a copy to me regarding all of our benefit claims with respect to Comprehensive Orthopaedics & Rehabilitation. I specifically direct payment by any such entity or under any such plans, policies and programs to be made directly to Comprehensive Orthopaedics & Rehabilitation for services and items provided to me and my dependents. In the event payment is made to me contrary to this agreement, I will promptly turn over payment in full to Comprehensive Orthopaedics & Rehabilitation. This assignment and power of attorney includes, but are not limited to, claims or causes of action that I may have relating to any insurance policy or health benefits plan or any other party under ERISA, under state insurance law and under state common law. I further assign to Comprehensive Orthopaedics & Rehabilitation and its agents all rights, claims or causes of action I may have to request and obtain documents from any health plan and its affiliated insurers, employers and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy or governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that Comprehensive Orthopaedics & Rehabilitation can determine if a full and fair review of my claim took place. I assign to Comprehensive Orthopaedics & Rehabilitation and its agents my rights and any claims or causes of action I may have to collect any penalties for my health plan's failure to timely produce this required information. If my account becomes delinquent and it is referred to an attorney or collection agency, I agree that I will pay all charges, interest from the due date (*i.e.*, thirty (30) days after receipt of the clean claim) at eighteen percent (18%) or the maximum rate allowable by law, reasonable attorney fees, costs and collection expenses.

_____ _____

Guarantor / Patient Signature Date

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Certified Orthopaedic Physician Assistant

Consent for Treatment

This facility has on staff a certified orthopaedic physician assistant to assist in the delivery of orthopaedic care.

A certified orthopaedic physician assistant is not a doctor. A certified orthopaedic physician assistant has completed a certified training program. Under the supervision of a physician, a certified orthopaedic physician assistant can diagnose, treat and monitor common acute and chronic orthopaedic illnesses as well as provide orthopaedic health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A certified orthopaedic physician assistant may provide such orthopaedic services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures including joint/bursa injections, suture/staple removal, dressing changes, casting/bracing, etc.
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery and performing post-operative checkups
- Offering counseling and education
- Writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a certified orthopaedic physician assistant for my health care needs.

I understand that at any time I can refuse to see the certified orthopaedic physician assistant and request to see a physician.

X_____ _____

Patient Signature Date

_____

Printed Name

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Comprehensive Orthopaedics & Rehabilitation, P.A.
HIPAA Notice of Privacy Practices

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

THIS NOTICE IS A REVISION AND BECAME EFFECTIVE 2/20/2023

If you have any questions about this notice, please contact Cassie Babarovic, Practice Manager.

PROVIDER/CLINIC OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect
- In Texas, Inform you that we disclose your PHI electronically
- In Texas we will not email patients without written consent
- Notify you of a breach of protected information as required by federal and state law

PROTECTED HEALTH INFORMATION:

Protected health information is defined by HIPAA as individually identifiable health information; it can be verbal, written or electronic.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and obtain a copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Cassie Babarovic, Practice Manager. In Texas, we have up to 15 days to

make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Cassie Babarovic, Practice Manager.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Cassie Babarovic, Practice Manager.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Cassie Babarovic, Practice Manager. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your

Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Cassie Babarovic, Practice Manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.comprehensiveortho.com. To obtain a paper copy of this notice, contact Cassie Babarovic, Practice Manager.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page of the notice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Cassie Babarovic, Practice Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Required Notice Under the Texas Health and Safety Code, Sec. 181.154 – HB 300

Because Comprehensive Orthopaedics & Rehabilitation, P.A. gathers, stores and electronically transmits medical records (Protected Health Information – PHI), we are required to provide notice to patients that their protected health information is subject to electronic disclosure.

Texas Law prohibits any electronic disclosure of a patient's protected health information to any person without a separate authorization from the patient for each disclosure. This authorization for disclosure may be made in written or electronic form or in oral form if it is documented in writing by Comprehensive Orthopaedics & Rehabilitation, P.A.

The Authorization for electronic disclosure of protected health information described above is not required if the disclosure is made: to another covered entity, as that term is defined by Section 181.001, or to a covered entity, as that term is defined by Section 602.001, Insurance Code, for the purpose of: treatment; payment; health care operations; performing an insurance or health maintenance organization function described by Section 602.053, Insurance Code; or as otherwise authorized or required by state of federal law. In other words, no further release is necessary for electronic disclosure to other health care providers, insurance companies, governmental agencies, or defense lawyers representing adverse parties.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR COMPREHENSIVE ORTHOPAEDICS & REHABILITATION, P.A.

Patient Name: _____

Date of Birth: _____

I acknowledge that Comprehensive Orthopaedics & Rehabilitation, P.A. provided me with a written copy of its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient