Center for Neurological Disorders, P.A.
1319 Summit Avenue, Fort Worth, Texas 76102
1-888-339-9629 (Toll Free) (817) 336-0551 FAX (817)339-3940

George F. Cravens, M.D., FACS Lee Kesterson, M.D. Gregory Ward, M.D. Kevin Kaufman, M.D. Gregory Smith, D.O

Accommodating Reasonable Requests for Confidential Communications

Purpose:
In keeping with patient rights established under the Health Insurance Portability and Accountability Act (HIPAA), and this office's commitment to allowing patients an opportunity to control disclosures of their protected health information (PHI), we will accommodate all reasonable requests for confidential communications that we receive from our patients or their representatives.

Policy:
Notice of each patient's right to make reasonable requests for confidential disclosures is included in the *Notice of Privacy Practices* that is posted in our office and provided to all patients.

- This office recognizes the rights of any patient to request that we restrict our use or disclosures of their PHI to carry out treatment, payment, or health care operations.

- While we cannot necessarily agree to all requests, we will comply with any that are reasonable, and will honor those restrictions *unless* the patient is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment. If a disclosure is made pursuant to eme3rgency treatment, we will request that the other provider not further use or disclose the information.

- Any agreed upon restriction will not prevent this office from complying with any disclosures required by federal or state law, or federal or state authorities. See *Mandatory Disclosures* policy and procedure.

- Any request to restrict disclosures can be terminated by the patient, if the revocation is in writing, or if he/she orally agrees to the termination that oral agreement is documented.

- This office will accommodate any reasonable request for communications from this office to be performed through alternative means or locations, e.g., alternative address, alternative telephone number, all mail in closed envelopes, if the request

is practicable, in writing, and does not deny this office appropriate contact for treatment, operations, and/or payment purposes.

- All patients will be notified in our *Notice of Privacy Practices* that it is our standard procedure to send appointment reminders in the mail and/or leave telephone answering machine messages, but that they have the right to request that we not do either if they make that request in writing.

- This office will not ever require an explanation from the patient as to the basis for the request that he or she is making.

Privacy Officer

B. Coleman

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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. You can request a copy of this notice at any time. For more information about this notice or our privacy and policies, please contact the person listed below.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care. OR

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

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or 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 taken in reliance 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 that may be using.

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

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

Legal 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 that the information:

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

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

Workers' Compensation
We may disclose your medical information as required by the Texas 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 fare, 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 (fi you are in the military), authorized national security and intelligence activities, as well as authorized activity 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 examiners to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

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

Your Rights Under Federal Privacy Regulations

The United States 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 a patient that exercises 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 healthcare operations. We do NOT have to agree to these restrictions, but if we do agree, we will comply with your request except under emergency circumstances.

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

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

Receiving Confidential Communications by 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 are 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 below.

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

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

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

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

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

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

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

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendem4ent we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures
The 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 listed below. 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 you request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related 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.

Complaints

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

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

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.

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.

B. Coleman
1319 Summit Avenue, Suite 200
Fort Worth, Texas 76102
(817) 336-0551, FAX (817) 339-3940

This notice is effective on the following date:

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 notes in the office where it can be seen.

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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

I ____ have read and understand the Patient Policy and Procedure Guide for Center for Neurological Disorders, PA.

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CONFIDENTIAL PATIENT AGENDA

Dear Patient: To help you make the best use of your time with our physicians, please list the questions you would like to discuss during your appointment.

1.____

2.____

3.____

4.____

5.____

Signature ____ **Date** ___________________

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ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to Center for Neurological Disorders, PA., and major medical benefits due me.

WHERE NOT PRECLUDED BY CONTRACTUAL AGREEMENT, I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

____
Signature (Patient or Legal Representative)

____
Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Center for Neurological Disorders, PA. to release information requested by my insurance company or Workers' Compensation carrier. I also authorize the Center for Neurological Disorders, PA. To release information to any hospital or physicians to whom I may be referred by this office.

____
Signature (Patient or Legal Representative

____
Date

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Medical Record Release Form

By signing this form, I authorize you to release confidential and protected health information about me, by releasing a copy of my medical records, or a summary or narrative of my health information, to the person(s) or entity listed below

HIV/AIDS: I consent to the release of any positive or negative result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial________________ Date___________________

Limitations on the information you may release subject to this Release Form are as follows:

____

Release my protected health information to the following person(s)/entity:

Name ___________________________ Street address__________________________________

City_____________________________ State and Zip code______________________________

Name ___________________________ Street address__________________________________

City_____________________________ State and Zip code______________________________

The reasons or purposes for this release of information are as follows:

____
____
____

Patient Signature (or parent, guardian or legal representative):

_________________________________ Date ____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice.

B. Coleman
Privacy Officer

HIPPA BUSINESS ASSOCIATES

Doctors Answering Service
PO Box 26631
Fort Worth, Texas 76126

Robert Watson/Hanes and Boon
PO Box 841399
Dallas, Texas 75284

Chris Green, CPA
412 Ridgewood Road
Fort Worth, Texas 76107

ISA Information Systems
2800 Shirlington Road, Suite 1100
Arlington, VA 22206-3601

Longhorn Neuro Services
2834 S.E. Loop 820
Fort Worth, Texas 76140

Donna Karbs
RR #2, Box 400 B
Marlow, OK 73055

Medical Manager Software
15149 N. W. 99th Street
Alachua, FL 32615

SYNK Medical Services
6840 North Park
Fort Worth, Texas 76180

Texas State Board of Medical Examiners
Austin, Texas

Credit Systems
1277 Country Club Lane
Fort Worth, Texas 76112

TMLT
PO Box 847512
Dallas, Texas 75284

Texas Medical Association Insurance Trust
PO Box 1707
Austin, Texas 78767

Medical Protective Insurance
Omaha, NE

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Acknowledgement of Review of Notice of Privacy Practices Of CND

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

____
Signature of Employee

____
Date

____
Name of Employee