NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security #: _____ Sex: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Race: _____ Ethnicity: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: Cell: _____ Home: _____ Work: _____

Preference for appointment reminder: Home ☐ Work ☐ Cell ☐ May we leave a voicemail message? Yes ☐ No ☐

Are you Employed: Yes ☐ No ☐ A Full Time Student: Yes ☐ No ☐ Disabled: Yes ☐ No ☐ Retired: Yes ☐ No ☐

Email Address: _____

Name of Employer: _____ Phone: _____ Fax: _____

Is the patient a minor? Yes ☐ No ☐ - *If Yes, please fill out the information below:*

Parent(s)/Guardian(s) Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Guardian Phone Number: Cell: _____ Home: _____ Work: _____

***If the patient has been appointed a court-appointed guardian, the guardian must be present for all appointments and must sign all signature required documents. ***If the court-appointed guardian is not present, the appointment will be rescheduled.

EMERGENCY CONTACTS AND OTHER CURRENT PHYSICIANS

Spouse's Name: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Specialist Physician: _____ Phone #: _____

Specialist Physician: _____ Phone #: _____

Counselor/Therapist: _____ Phone #: _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
Primary Insurance: _____	Secondary Insurance: _____
Subscriber ID#: _____	Subscriber ID#: _____
Group#: _____	Group#: _____
Plan Name: _____	Plan Name: _____
Policy Holders Name: _____	Policy Holders Name: _____
Policy Holders DOB: _____	Policy Holders DOB: _____
Policy Holders SS#: _____	Policy Holders SS#: _____
Relationship to Patient: _____	Relationship to Patient: _____

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Patient Representative Date

CURRENT MEDICATIONS
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Drug Allergies

Please list any drug allergies and exactly how this medication affects you. (Examples: Rash, Hives, Itching, Swelling, etc.)

Medication Name: _____ Type of Reaction: _____

Medication Name: _____ Type of Reaction: _____

Medication Name: _____ Type of Reaction: _____

Medication Name: _____ Type of Reaction: _____

Pharmacy Information

Please list your pharmacy information. Please present a copy of your prescription card to the front desk.

Local Pharmacy Name: _____ Pharmacy Number: _____

Mail Order Pharmacy: _____ Pharmacy Number: _____

Other Physician Information

Please list your Primary Care Physician and any other physician that we may coordinate your care with.

Primary Care Physician: _____ Phone Number: _____

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Patient Representative **Date**

Authorization to Disclose Health Information
Medical Records Release

Patient Name (Please print) ______________________ Date of Birth ______________________

Social Security Number ______________________ Phone Number ______________________

I HEREBY AUTHORIZE DISCLOSURE OF INFORMATION TO/FROM THE NAMED INDIVIDUALS OR ORGANIZATION(S) LISTED BELOW:

Full Name or Person/Organization/Physician's Office ______ Relationship to Patient ______ Phone Number ______

☐ Release all Health Information
☐ Release all Billing Information (including payments, collections, etc.)
☐ Release Other (Please specify): ______
☐ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE

Full Name or Person/Organization/Physician's Office ______ Relationship to Patient ______ Phone Number ______

☐ Release all Health Information
☐ Release all Billing Information (including payments, collections, etc.)
☐ Release Other (Please specify): ______
☐ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE

Full Name or Person/Organization/Physician's Office ______ Relationship to Patient ______ Phone Number ______

☐ Release all Health Information
☐ Release all Billing Information (including payments, collections, etc.)
☐ Release Other (Please specify): ______
☐ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE

- **I understand that incomplete forms will be null and void; no exceptions.**
- I understand that disclosure of my health information does not include mailing or faxing copies of my medical records; I must complete a medical records release in order to have copies of my medical records mailed or faxed to the named individual(s) or organization(s).
- I understand that specific information to be disclosed may include history of Drug or Alcohol Abuse or Mental Health Treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Immune Deficiency Syndrome (AIDS), laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Pandora's House Psychiatry Privacy Officer: 107 McKinney Street, Farmersville, Texas 75442 Phone: 972-784-3064 Fax: 972-784-3069.

Print Patient Name ______ Patient/Guardian Signature ______ Date ______ Relationship ______

Witness Signature ______ Title ______ Date ______

Agreement for Controlled Substances

It is our desire to provide you with excellent patient care and to help you achieve overall health and wellness. To help achieve that goal, your provider may prescribe a Controlled Substance medication (i.e., narcotics, sedatives benzodiazepines, stimulants and/or buprenorphine) which can be very useful, but have a significant potential for misuse and are, therefore; closely controlled by local, state, and federal authorities. In addition, the Texas Medical Board encourages urine drug screens in conjunction with a controlled substance contract to start or continue taking any controlled substance. Failure to sign and abide by this agreement will result in immediate termination of any controlled substances being prescribed by any provider in this office. Please carefully read through the entire agreement and initial by each item and fill your name in, indicating that you understand these requirements set forth by all Pandora's House Psychiatry. We look forward to working with you.

Sincerely,
Pandora's House Psychiatry

1. I am responsible for my medications. If the medications are lost, misplaced, or stolen, **REGARDLESS OF THE REASON**, I understand that my physician **WILL NOT** be replacing or refilling my medication. I further understand that early refills **WILL NOT** be approved. **(INITIAL)** _____

2. I **WILL NOT** seek medications from any other physician or practitioner while I'm receiving the same medications from my provider of Pandora's House Psychiatry. We will regularly check the Texas Prescription Monitoring Program data base. The data base tells your provider of each prescription for controlled substances that you have filled from all practitioners and pharmacies. **(INITIAL)** _____

3. **Suboxone Patients**: I **WILL NOT** seek opiate medications from any other physician or practitioner while I'm receiving Suboxone therapy from my Provider of Pandora's House Psychiatry. I further agree to inform my Provider of Pandora's House Psychiatry of any and all medical or dental procedures that will require the use of opiate medications. I agree to disclose to the surgical or medical physician that I am on Suboxone therapy and will sign a Release of Information for the physicians to consult regarding medications and all surgical or medical procedures. **(INITIAL)** _____

4. Concerning refills: I agree that refills of **controlled substance medications will be made during regular office hours, in person, during a scheduled visit. It is your responsibility to take the medication as prescribed. Early refills will not be made, even if you have run out of your medication early. (INITIAL)** _____

5. **I WILL TAKE my medications as prescribed** and as directed. I will not take ***extra*** medication without being advised to do so by my provider at Pandora's House Psychiatry. By doing so ensures that I will not run out of medications early. **(INITIAL)** _____

6. I **WILL NOT** use any illicit drugs, as defined by law. These include marijuana, heroin, methamphetamine, cocaine, PCP and hallucinogens or any other mood-altering substance that is illegal. **(INITIAL)** _____

7. I understand that Pandora's House Psychiatry will perform urine drug screening tests, at my expense, to verify compliance of my medication contract. If I am found to be using illegal substances for any reason, my Controlled substance medications will be discontinued immediately. **NO EXCEPTIONS.** In addition, if my urine drug screen is negative for medications prescribed by Pandora's House Psychiatry practitioners, my controlled substances medications will be discontinued immediately and will not be re-prescribed by any physician at Pandora's House Psychiatry. **NO EXCEPTIONS. (INITIAL)** _____

8. I understand that if I violate any of the above conditions, my controlled substance prescriptions will be immediately terminated, and it will be reported to my other healthcare providers, medical facilities and pharmacies.
(INITIAL) _____

9. I understand that my provider may discontinue my medication at any time if they no longer think it is clinically appropriate or in my best interest. Additionally, if my controlled substances are discontinued by my Pandora's House Psychiatry provider, this will apply to all other Pandora's House Psychiatry Providers as well. **No other practitioner in this practice will restart you on the medication. Lastly, once you have violated the agreements in this contract at no time will you ever be prescribed controlled substance by this practice again.**
(INITIAL) _____

I acknowledge the receipt of this agreement and that it has been explained to me in detail by a staff member at Pandora's House Psychiatry. I understand by signing below, I agree to comply with the terms and guidelines of this agreement.

Patient Name (Please Print) _____Date_____

Signature of Patient or Guardian_____Relationship_____

Office Policies

Office Hours and Emergencies

Our office hours are Mon through Fri, 9 AM to 5 PM. Our office is closed on all major holidays. We do not provide emergency services, crisis services, weekend, or after-hours coverage. If you have a life-threatening emergency, please go to the nearest emergency room or call 911.

Consent for Treatment

I authorize the physicians and clinic personnel of Pandora's House Psychiatry to conduct physical examinations and routine services, order and perform tests, and administer any treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and that additional consent(s) may be required.

Insurance

Medical expenses are the patient's responsibility regardless of insurance coverage. While we will attempt to verify your benefits with your insurance company as a courtesy, any copay, coinsurance and deductible information provided to us from your insurance company is not a guarantee of insurance coverage or payment. If the patient has a secondary insurance policy, once the primary insurance carrier has made their payment we will file your claims as a courtesy to your secondary insurance. If we do not receive payment after forty- five (45) days from the date we filed the claim, the balance will become the patient responsibility. Patients are responsible for knowing the stipulations of their insurance policy. If for some reason your insurance company fails to pay for services rendered and/or you are not eligible at the time the services are rendered, the patient is still responsible for payment. You also agree to take full responsibility for the entire amount due for any and all services rendered that are not covered by your insurance carrier. You are responsible to timely notify our office for any changes of insurance or demographics information.

Assignment of Benefits

I authorize my insurance carrier(s) to remit payment of benefits for any claim to Pandora's House Psychiatry. I understand that any ineligible or non-covered expenses are my responsibility. I assign Pandora's House Psychiatry, as an Authorized Representative to: (1) Submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) Submit any and all requests for benefit information from my insurance company, (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) Release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy, and/or settlement information upon written request from Pandora's House Psychiatry. This assignment is valid for all administrative and judicial reviews under all applicable federal and/or state laws. A photocopy of this assignment is to be considered as valid as the original.

Medication refill policy

You are responsible for scheduling a follow-up with your provider before any prescription runs out. All refills and changes in medications are done during an office visit. **If a refill is needed outside of an office visit, request your pharmacy to send over the request electronically and allow 48-72 hours to process. We only provide treatment and medication management for controlled substances (Suboxone, Adderall, Ambien, etc.) during an appointment**. It is the patient's responsibility to take the medication as prescribed. **Early refills will not be made before the refill date, and is the provider's discretion to approve or deny refill requests.** Unless you are directly approved by a provider at your appointment that you can be seen every 90 days, your medication will get denied for refill.

Cancellations and missed appointments

If you need to cancel an appointment, a 24 business hour notice is required. If you miss or cancel an appointment without a 24 business hour notice, you will be charged $50 for the missed appointment. Missed appointments cannot be filed with insurance, therefore you are solely responsible for this fee. After 3 missed appointments, we will no longer provide services unless all missed appointments are paid in full.

Continued →

Medication Prior Authorization

Prior authorization requests need to be sent to our office by the pharmacy electronically. Please allow 48-72 hours for your insurance to process the request. We advise each patient to obtain a copy of your formulary list prior to your visit, to ensure that the medications being prescribed are covered by your insurance company, and to give you the opportunity to discuss alternatives if possible. This will help to avoid charges incurred secondary to this policy.

Paper work

There is a $25.00 charge for all Short Term and Long Term Disability, FMLA, ADA Accommodations or other paperwork that require a physician to complete. Please present your paperwork to the receptionist prior to your appointment. It's at your provider's discretion to complete it or not. All paperwork will require 7 business days to be completed, regardless of the due date as it is the patient's responsibility to get the paperwork to us in a timely manner.

Returned checks

There is a $30 charge for any returned checks.

Medical records

If you need a copy of your medical record, you must give Pandora's House Psychiatry office a signed records request/release from the patient. Fees for medical records are $25.00 for the first 20 pages, and $0.50 for each page thereafter and may take up to 15 business days to obtain.

Labs

We may need to order labs (ex. Drug Screens) in some cases. Please note the cost of the labs and injections are not included in your visit charges. Your insurance may not cover these services and will be the patient's financial responsibility. Pandora's House Psychiatry send lab request to LabCorp and Quest Diagnostics for our patient's lab work.

Communications

We may contact you by (telephone, mail, email) to provide appointment reminders, information regarding medical advice or results or any other health related services that may aid in your care.

Confidentiality

We are required by law and regulation to protect the privacy of your medical information as outlined in Pandora's House Psychiatry privacy practices. Pandora's House Psychiatry notice of privacy practices can be viewed on our website, at the front office of all clinic locations and a paper copy is able to be provided to the patient anytime per their request.

Danger

In the event that your provider, in their clinical judgment believes you to be a danger to yourself or to someone else, by signing this consent you authorize Pandora's House Psychiatry to contact either the person listed as your emergency contact or someone else to provide assistance through a crisis situation. If at any time a patient shows hostile or threatening behavior to the employees or patients of Pandora's House Psychiatry, the police will be contacted and the patient will no longer be able to receive care at any Pandora's House Psychiatry clinics.

Right to withdraw

If a conflict arises for the client or the physician/provider, either has the right to withdraw from the treatment. If the provider feels the need to withdraw from providing treatment, Pandora's House Psychiatry will inform the patient and will try to provide appropriate referrals and 30-day emergency care.

By signing below, you acknowledge that you have read and understand the policies listed above. Furthermore you give authorization of payment of medical benefits to our office for services rendered. Terms and condition are subject to change.

Patient Name (Please Print) _____ Date _____

Signature of Patient or Guardian _____ Relationship _____

HIPAA 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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. A new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. Copies of this Notice are available from our receptionists, by mail, or by accessing our website http://www.pandorashousepsychiaty.com.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information for Which Your Authorization Is Not Required. Your PHI may be used and disclosed without your prior authorization by your physical therapist, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapist's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your protected heath information may be provided to a physical therapist to which you have been referred to ensure that the physical therapist has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physical therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physical therapist. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Opportunity to Object. We may use and disclose your PHI in the following instances. You have the opportunity to object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Health 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 PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such disclosure, we may disclose such information as

necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for the care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your healthcare provider or another healthcare provider in our agency is required by law to treat you and the healthcare provider has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object. We may disclose your PHI in the following situations without your consent or authorization:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable Diseases: We may disclose your PHI, 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 your PHI 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, and other government regulatory programs.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI 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.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration (i) to report adverse events, product defects or problems, biologic product deviations, track products; (ii) to enable product recalls; (iii) to make repairs or replacements; or (iv) to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors and Organ Donation: We may disclose your PHI 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 PHI 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. PHI may be disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI 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 PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may use or disclose your PHI 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.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel: (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of a determination by the Department of Veterans Affairs; or (iii) to foreign military authority if you are a member of the foreign military services.

Workers' Compensation: We may use or disclose your PHI as authorized to comply with workers' compensation laws and other similar legally established programs.

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

Fundraising: We may contact you to raise funds. We may use and disclose your PHI, including demographic data, dates of health care provided, the department from which you received the services, the name of the treating physician, outcome information and health insurance status, to a business associate or institutionally related foundation for fundraising purposes without your authorization. You have the right to opt out of receiving fundraising communications from us, our business associates and our institutionally related foundations. Each fundraising communication will provide you with a clear opportunity to elect not to receive further fundraising communications.

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 requirements of the Code of Federal Regulations, Part 45 Section 164.500 et seq.

Uses and Disclosures of PHI for which Your Written Authorization Is Required. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You make revoke this authorization, at any time, in writing, except to the extent that your physical therapist or The Therapy Network has already taken an action in reliance on the use or disclosure indicated in the authorization.

The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

2. <u>Your Rights</u>. Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

<u>You have the right to inspect and copy your protected health information</u>. This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for so long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your health care provider and the Therapy Network uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You also have a right to restrict certain disclosures of your PHI to a health plan if you have paid in full out-of-pocket for the health care item or service.

Your health care provider is not required to agree to a restriction that you may request. If your health care provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider. If your health care provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

You may have the right to have your physical therapist amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for general notification purposes. You have the right to receive specific information regarding these disclosures that occurred after June 13, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us. You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.

You have a right to receive notifications of a data breach. We are required to notify you upon a breach of any unsecured PHI. PHI is "unsecured" if it is not protected by a technology or methodology specified by the Secretary. The notice must be made within 60 days from when we become aware of the breach. However, if we have insufficient contact with you, an alternative notice method (posting on website, broadcast media, etc.) may be used.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of Pandora's House Psychiatry please contact:

Privacy Officer
Christi London
107 McKinney Street
Farmersville, Texas 75442
972-784-3064

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or you may file a complaint 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 practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights 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

OUR RESPONSIBILITIES

Pandora's House Psychiatry is required by law and regulation to protect the privacy of your health 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.

_____ _____

Signature **Date**