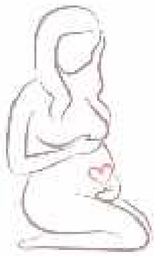

Wei Zhang MD PhD FACOG
Midway Medical Center
3108 Midway Rd. STE. 100
Plano, TX 75093
972-608-0900 (office) 972-608-8989 (fax)

Patient Registration Information

Report Date:			
Last Name:	First Name:	Middle Initial:	
Patient Race:	Marital Status:	Ethnicity:	Language Preference:
Date of Birth:	Age:	SSN:	
Home Phone:	Mobile Phone:		
Work Phone:	E-mail Address:		
Street Address:			
City:	State:	Zip Code:	
Emergency Contact's Name:	Emergency Contact's Phone Number:	Relation to Patient:	

Preferred Pharmacy Information

All of your prescriptions will be sent directly to this pharmacy of your choosing. Please let us know if you need help finding one.

Pharmacy Name:
Pharmacy Address:
Pharmacy Phone:
Pharmacy Fax:

Wei Zhang MD PhD FACOG
Midway Medical Center
3108 Midway Rd. STE. 100
Plano, TX 75093
972-608-0900 (office) 972-608-8989 (fax)

In order to protect your privacy, we ask that you complete the following form. This will enable us to serve you better in the future. Please check the appropriate box beside each statement. We also ask that you enter the name of each person you would like to have access to your account (this includes your spouse). Also, please sign and date the bottom of this form. Please note that you may update this information at any time. Thank you for your cooperation.

I hereby authorize the office of Wei Zhang MD PhD FACOG & Jacquelyn E. Alvarado DNP RN CNM to leave information regarding my health care information, appointments, and/or account information in the following manner:

Yes ☐ No ☐ Home voicemail
Yes ☐ No ☐ Cell phone voicemail
Yes ☐ No ☐ Work voicemail
Yes ☐ No ☐ Leave message with family member

I hereby authorize the office of Wei Zhang MD PhD FACOG & Jacquelyn E. Alvarado DNP RN CNM to leave information regarding my labs and test results that are normal or abnormal in the following manner:

Yes ☐ No ☐ Home voicemail
Yes ☐ No ☐ Cell phone voicemail
Yes ☐ No ☐ Work voicemail
Yes ☐ No ☐ Leave message with family member

I hereby authorize the office of Wei Zhang MD PhD FACOG & Jacquelyn E. Alvarado DNP RN CNM to speak to the following people regarding my health care information, appointments, and/or account information in the following manner:

1.	Relation to patient:
2.	Relation to patient:
3.	Relation to patient:

Patient's Name Printed: ____ Date: ____________________

Patient's Signature: ____

Wei Zhang MD PhD FACOG
Midway Medical Center
3108 Midway Rd. STE. 100
Plano, TX 75093
972-608-0900 (office) 972-608-8989 (fax)

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS & INFORMATION RELEASE

I authorize the release of any medical information necessary in the processing of my claim. I authorize payment directly to the office of Wei Zhang MD PhD FACOG & Jacquelyn E. Alvarado DNP RN CNM. This agreement will remain in effect until revoked by me (the patient) in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said designee to release all information necessary to secure the payment

POLICIES

- Please be advised that a $25.00 fee will be applied to your account for appointments that have not be rescheduled or canceled 24 hours in advance.
- Payment will be due the day services are rendered. This includes co-pays.
- Outstanding balances should be paid prior to visit.
- We aim to see patients on time, however, in the event of a delay of 30 minutes or more, you are welcome to reschedule.
- Please be courteous to other patients by arriving to your scheduled appointment on time. All patients that arrive 15 or more minutes late might be required to reschedule that visit.

Wei Zhang MD PhD FACOG
Midway Medical Center
3108 Midway Rd. STE. 100
Plano, TX 75093
972-608-0900 (office) 972-608-8989 (fax)

AUTHORIZATION FOR CARE

- ✓ I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- ✓ No guarantees or promises have been made to me about expected results of my care.
- ✓ I am aware that other risks and complications may occur. I also understand that during the remainder of my pregnancy, or during labor, unforeseen conditions may be revealed that require additional procedures. I authorize my providers to perform the additional procedures as they deem necessary or appropriate.
- ✓ I know that Wei Zhang MD, Ph.D and/ or Jacquelyn Alvarado DNP, RN, CNM will be my provider and perform my office visits. Either provider may be present at my delivery.
- ✓ I retain the right to refuse any specific treatment.
- ✓ All of my questions have been answered.

BLOOD TRANSFUSION

- ☐ I accept blood transfusions in the case of a life-threatening medical emergency.
- ☐ I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

I voluntarily consent to Wei Zhang MD, Ph.D. and/ or Jacquelyn Alvarado DNP, RN, CNM to provide care to me. I understand that some of the procedures described above may occur. I retain the right to refuse any specific treatment. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

______________________________ ____________________

Patient Name (print) DOB or Patient ID#

______________________________ ____________________

Patient Signature Date

Wei Zhang, M.D., Ph. D., P.A.

3108 Midway Rd Ste. 100
Plano Tx 75093
Phone: 972-608-0900
Fax: 972-608-8989

Authorization to Release Healthcare Information

Patient's Name:______________________ Date of Birth:______________________

Social Security #:____________________ Address:____________________________
____

REASON FOR RECORDS: THIS IS A NEW PATIENT FOR DR ZHANG.

I request and authorize:____
(PHONE)_____________________ **(FAX)**_________________
to release healthcare information of the patient named above to:

DR WEI ZHANG MD PhD FACOG
3108 Midway RD Ste 100
Plano, TX 75093
Phone # 972-608-0900 Fax # 972-608-8989

This request and authorization applies to:
__ Healthcare information relating to the following treatment, condition, or dates:
____
__ All healthcare information
__ Other:____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 ET SEQ., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

__ yes __no I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person listed above will be notified that I must give specific written permission before disclosure of these test results can be given.

__ yes __no I authorize the release of any records regarding drug, alcohol, or mental treatment to the person listed above.

Patient Signature:_____________________________ Date___________________

Witness:_____________________________________ Date___________________

Wei Zhang, M.D., Ph. D., P.A.
3108 Midway Rd Ste 100
Plano TX 75093
972-608-0900 (office)
972-608-8989 (fax)

CONSENT

I give, Wei Zhang, MD, PhD, PA my consent to use or disclose my health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that the practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction.

I also understand that my revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name: Patient Name
DOB:Date of Birth

Wei Zhang, M.D., Ph. D., P.A.

3108 Midway Rd Ste 100
Plano TX 75093
972-608-0900 (office)
972-608-8989 (fax)

IMPORTANT INFORMATION PLEASE READ

DISCLOSURE OF INSURANCE INFORMATION

AS THE PATIENT IT IS YOUR RESPONSIBILITY TO DISCLOSE ALL INSURANCE INFORMATION, INCLUDING ANY ADDITIONAL INSURANCE AND COVERAGE. FAILURE TO DO SO IS AGAINST THE LAW AND COULD CAUSE YOU TO BE INELIGIBLE FOR ALL COVERED BENEFITS AND LEAVE YOU RESPONSIBLE FOR THE ENTIRE COST OF YOUR HEALTH CARE. YOU MUST NOTIFY OUR OFFICE IMMEDIATELY WITH ANY NEW INSURANCE OR CHANGES TO YOUR EXISTING POLICY. AS A COURTESY TO YOU WE DO OUR BEST TO VERIFY YOUR COVERAGE PRIOR TO YOUR VISIT, BUT "**VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT". THIS IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY AND IT IS YOUR RESPONISBILITY TO KNOW THE TERMS OF YOUR PLAN.** IF FOR ANY REASON YOUR INSURNACE DOES NOT COVER ANY CHARGES FOR SERVICES RENDERED IT WILL BE YOUR RESPONIBILITY TO PAY YOUR ACCOUNT IN FULL AT THE EARLIEST POSSIBLE TIME.

I UNDERSTAND THAT I AM RESPONIBLE FOR FULL PAYMENT TO THE PRACTICE FOR ANY AND ALL SERVICES THAT MAY NOT BE COVERED BY MY INSURANCE PLAN.

Patient Financial Responsibility

Wei Zhang, MD, PHD, PA

will provide medical services and in turn patients will be held liable for that portion of the cost of medical care for which they are responsible. Wei Zhang MD, PHD, PA will make every effort to work with patients to resolve their financial obligation to the facility.

Insurance/Third Part Payors

The practice will assist out patients in making every effort to collect payments from the patients or guarantors insurance company through courtesy filing of insurance claims and other required documentation. Since most carriers have time limits for filing correct information, it is imperative that we receive complete and correct insurance information. Though assistance will be provided, it is the patient's responsibility to make sure his/her insurance carrier pays his/her claim. Patient's or their guarantors are responsible for payment in full of their financial obligations whether or not their insurer makes payment.

Many insurance companies do not cover preventive services (annual examinations, immunizations, screening tests, etc.) or treatment/counseling for infertility or pre-pregnancy/family planning counseling. **Some (but not all) of services that may not be covered by your insurance are:**

- Immunizations: Hepatitis B, Influenza, MMR, Pneumovax, Tetanus
- Injections: Depo Provera, Depo Lupron , Rhogam
- Screening Test: Cholesterol, Diabetes, Thyroid
- Office visits for infertility, well woman care, pre-pregnancy/ family planning counseling

We do our best to very your coverage prior to your visit, but we cannot guarantee payments of benefits by your insurance plan. This is a contract between you and your insurance company and your responsibility to know the terms of your plan.

Routine Preventative Services

Please be advised that if you have scheduled a preventative visit (well woman) or a contraceptive visit and upon arriving for appointment you inform us of a sick visit issue, we will either reschedule your well woman visit, and care for your immune issue, or we can perform both services which would be considered 2 separate visits, requiring separate co-payments, and will be responsible to pay both co-payments. Co- payments are due at time of service. For your convenience we can bill you your co-pay, but there will be a $15 charge to cover administrative services.

Self-Pay and/or Obligations Due after Insurance/Third Party Payment

Patients who have no other source of payment or have an account balance due after payment from your insurance are responsible for payment of their account in full within 30 days. Failure to satisfy patient's financial obligations may require the practice to transfer your account to a collection agency and may impact your credit rating. In the event that your account is transferred to a collection agency, you will be responsible for all costs including court costs, collection fees, and up to 20% attorney fees.

Charges for Services by Hospital or other Healthcare Professionals

Charges for services by Anesthesiologists, Pathologist, Hospital or other healthcare professionals are not part of your bill at Zhang MD, PHD, PA office, and will be billed separately by those private practitioners or facilities .

I understand that I am responsible for the full payment to Wei Zhang MD, PHD, PA for any services that may not be covered by my insurance plan.

*******Please be advised that a $25.00 fee will be added to your account for appointments that you have not cancelled or rescheduled 24 hours in advance. Please also be courteous to the other patients arriving on time for your appointments. All patients arrive 15 or more minutes late might be required to reschedule their appointment.*******

Patient Name

PATIENT CONSENT FORM TO TEST FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

I Patient Name authorize and consent to the testing of my blood in order to detect whether or not I have Human Immunodeficiency Virus (HIV), or its antigen or antibody, which is the probable causative agent of Acquired Immunodeficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood.

I understand that the blood tests are not 100% accurate, and that these blood tests sometimes produce “false positives” (positive results when the virus is not present) or “false negatives” (negative results when the virus is actually present), and that a potential need for confirmatory testing may arise.

I further understand that the presence of HIV antibodies means that a person probably has been infected with the AIDS virus, but does not necessarily mean that a person will develop AIDS.
I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks and alternatives tests, I should ask those questions of my physician before I consent to the blood test.

I acknowledge that information regarding measures for the prevention of the exposure to and transmission of Human Immunodeficiency Virus (HIV) has been made available to me prior to this test.

I understand that the results of this blood test will be recorded in my medical records and will be confidential. I further understand that such results will not be release to anyone not authorized to receive it. Subject to foregoing, Wei Zhang MD, PHD, PA office will not disclose the results of these tests to other except to the extent required by law

By my signature below, I acknowledge that this form has been explained to me, that I have read it or had it read to me, and that I have been given all the information I desire concerning the blood test and release of results, and have had all my questions answered. Further, by my signature, I acknowledge that I have significant information for informed consent for the performance of a blood test to detect antibodies to the HIV virus.

Wei Zhang M.D. PhD. P.A.
OBSTETRICS, GYNECOLOGY, INFERTILITY
AND LAPAROSCOPIC SURGERY

ULTRASOUND INFORMED CONSENT

Dr. Zhang's office has recommended an ultrasound. I, Patient Name, understand that this ultrasound is to be performed to check fetal growth, fetal number, dating of my pregnancy as well as other information that will be helpful in following my pregnancy. I understand that a routine ultrasound has many limitations and is not being performed to detect congenital defects, although occasionally certain significant and large defects may be identified. I also understand that ultrasounds are only 75% accurate in determining the sex of my baby and not specifically performed for this purpose.

Understanding the above, understanding that I may not know the gender of the fetus after this exam, and understanding that not all abnormalities may be discovered, I consent to this ultrasound examination.

A normal prenatal ultrasound examination by no means guarantees a normal baby at delivery.

By signing this form, I acknowledge that I have been given all the information I desire concerning this procedure and have had all my questions answered.

Wei Zhang MD PhD FACOG
Midway Medical Center
Suite 100
3108 Midway Rd.
Plano, TX 75093
972-608-0900 (office) 972-608-8989 (fax)

AUTHORIZATION FOR CARE

- ✓ I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- ✓ No guarantees or promises have been made to me about expected results of my care.
- ✓ I am aware that other risks and complications may occur. I also understand that during the remainder of my pregnancy, or during labor, unforeseen conditions may be revealed that require additional procedures. I authorize my providers to perform the additional procedures as they deem necessary or appropriate.
- ✓ I know that Wei Zhang MD, Ph.D will be my provider and perform my office visits. Either provider may be present at my delivery.
- ✓ I retain the right to refuse any specific treatment.
- ✓ All of my questions have been answered.

BLOOD TRANSFUSION

☐ I accept blood transfusions in the case of a life-threatening medical emergency.
☐ I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

I voluntarily consent to Wei Zhang MD, Ph.D. to provide care to me. I understand that some of the procedures described above may occur. I retain the right to refuse any specific treatment. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

____ ____________________________

Patient Name (print) DOB

______________________________________ ________________________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES*

Effective Date:

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.

WHO WILL FOLLOW THIS NOTICE?

- ✓ DR. WEI ZHANG
- ✓ All office employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at XXX, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

Wei Zhang M.D.'s office shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of 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; and

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- The office will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run XXX in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, XXX may provide a written or telephone reminder that your next appointment with XXX is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. 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, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If XXX determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If your are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for XXX. If you request a copy of the information, XXX may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  XXX may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by XXX will review your request and denial. The person conducting the review will not be the person who denied your request. XXX will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask XXX to amend the information. You have the right to request an amendment for as long as the information is kept by XXX.

  To request an amendment, your request must be made in writing and submitted to XXX. In addition, you must provide a reason that supports your request.

  XXX may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, XXX may deny your request if you ask us to amend information that:
    - Was not created by XXX, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the medical information kept by XXX;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

➢ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

To request this list you must submit your request in writing to _______. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. LORI will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

➢ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information XXX uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information XXX discloses about you to someone who is involved in your care or the payment for your care.

XXX is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which XXX has been paid out of pocket in full. Should XXX agree to your request, XXX will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to XXX. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit XXX's use and/or disclosure; and (3) to whom you want the limits to apply.

➢ **Right to Request Confidential Communications.** You have the right to request that XXX communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that XXX contact you only at work or by mail.

To request that XXX communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. XXX will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer .

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with XXX or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with XXX, contact the Privacy Officer at *(phone number)*. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.