DFW VASCULAR GROUP

SAMUEL S. AHN, MD, FACS
CRAIG A. FERRARA, DO, FACS
PABLO V. UCEDA, MD
JOSEPH M. CARUSO, MD, FACS
WILLIAM A. PEPER, MD, FACS, FCCP

WWW.DFWVASCULAR.COM

Dear Patient:

Welcome to DFW Vascular Group! We are happy that you have chosen us to participate in your healthcare and look forward to meeting you at your upcoming office visit.

Your initial visit with us will include a personalized, comprehensive exam along with easy-to-understand information and choices about how we can help you achieve your health goals.

We appreciate your busy schedule. Please plan to spend anywhere from two to three hours with us.

Our physicians are highly trained specialists who are committed to spending the time necessary to fully evaluate your individual needs and will customize a unique plan for your care. When you visit DFW Vascular Group, you will know you have been cared for in the most thorough, comfortable, and complete manner possible.

Please be prepared with the following items when you come for your appointment:

- **Completed forms.** Registration and medical history forms which are attached.
- **Insurance card and photo ID.** Please bring all current cards each time you visit.
- **Referral.** Written referral from your primary care physician, if required by your health plan.
- **Medications.** Please bring all medications or a complete list of all current medications, vitamins and supplements including strength and dosage information.
- **Test results.** Previous x-rays, ultrasounds, CT scans, lab tests & medical records related to your condition. This can usually be obtained from your referring physician or primary care physician.
- **Copay and/or co-insurance.** Payment is due at the time of service. Credit card options are offered to make your treatment affordable and convenient.
- **If you do not have insurance**, please call us at (214) 946-5165 for Colorado location or (972) 296-2122 for Bolton Boone location and we will give you an estimate of what you might expect to pay.
- **Patient Portal.** Some patients prefer to communicate with us via our patient portal at www.dfwvascular.com . You can request appointments, refill requests, and other information at your convenience rather than only during business hours.

Thank you again for selecting our office. Please do not hesitate to let us know how we can serve you best.

Sincerely,

The Physicians and Staff at DFW Vascular Group

DFW VASCULAR GROUP

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M / F
Last First Middle

Address: _____ Social Security # _____

City, ST, Zip_____ Married / Single / Divorced / Widowed / Other

Phone: _____ Language: _____ Race: _____
cell / home / work / other

Phone: _____ Ethnicity: (Circle One) Hispanic/Latino Not Hispanic/Latino
cell / home / work / other

Email address: _____ Preferred Method of Contact: Email / Cell / Home / Work / Other

Employer Name and Address: _____

GUARANTOR INFORMATION

Name: _____ Social Security # _____ DOB:_____
Last First Middle

Address: _____ Employer: _____

City,ST,Zip _____ Phone: _____
cell / home / work

EMERGENCY CONTACT

Name:_____ Phone: _____ Relationship: _____

PRIMARY INSURANCE

Ins Co Name:_____ Policy/Member #: _____ Group #: _____

Address: _____ Phone # _____

SECONDARY INSURANCE

Ins Co Name:_____ Policy/Member #: _____ Group #: _____

Address: _____ Phone # _____

ASSIGNMENT AND RELEASE

Release: I hereby consent to the release of information provided to, or generated by Samuel Ahn, M.D., Craig Ferrara, D.O., Pablo Uceda, M.D., Joseph Caruso, M.D., William A. Peper, M.D., to my primary care physician, referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.
Assignment: I hereby assign medical benefits otherwise payable to me to DFW Vascular Group. I understand and agree I am financially responsible for any unpaid balances for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all copays, deductibles, co-insurance and balances.
Verification: I hereby verify that all the above information is true and correct as of the date signed below.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Guardian or Legal Representative: _____ Date: _____

DFW VASCULAR GROUP

Patient Name: **Date of Birth:** **Today's Date:**

Reason for today's visit: _____

I was referred here by: Dr. _____ / Friend or Family / Internet / Insurance / Other_____

My Primary Care Physician is: Dr. _____ Phone # _____

My Dialysis Center is: _____ Phone # _____

Other Dr's & Phone #:_____

Pharmacy Name: _____ Location:_____Phone #:_____

****Please circle one** - In the event of hospitalization, I (**Do**) or (**Do Not**) consent to the use of blood products as deemed necessary.

Do you have advance directives? Examples include a Do Not Resuscitate Order or a Power of Attorney Yes / No

Have you ever received a blood transfusion? Yes / No When/Why _____

Is this visit related to a work or automobile injury? Yes / No

MEDICATIONS

Name of Medication	Dosage	Times Per Day

ALLERGIES

Allergic To What Food or Medication	Allergic Effect	Severity
		mild / moderate / severe / critical
		mild / moderate / severe / critical
		mild / moderate / severe / critical
		mild / moderate / severe / critical
Allergy to: Stainless Steel / Nickel / Cobalt / Chromium		mild / moderate / severe / critical

SOCIAL HISTORY

Do you smoke? Yes / Never / Occasional / Former When did you quit? _____

Do you drink alcohol? Yes / Never / Occasional / Former How much per day? _____

Do you drink caffeine? Yes / Never / Occasional / Former How much per day? _____

Do you use drugs? Yes / Never / Occasional / Former When did you quit? _____

Do you exercise? Yes / Never / Occasional Frequency _____ Type_____

DFW VASCULAR GROUP

Patient Name: **Date of Birth:** **Today's Date:**

PAST MEDICAL HISTORY

Please circle any that apply

Abnormal Chest X-ray	Crohn's Disease	Heart Valve Problems	Prolapsed Mitral Valve
Abnormal EKG	Decreased Appetite	Hemochromatosis	Psoriasis
Abnormal Mammogram	Decreased Walking	Hemophilia	Psychiatrist / Psychologist Visit
Abnormal Stress Test	Deep Vein Thrombosis	Hemorrhoids	Peptic Ulcer Disease
AIDS	Dental Problems	Hepatitis A / Hep B / Hep C	Pulmonary Embolism
Anal Fissures	Depression	Hiatal Hernia	Recent Kidney Tests
Anemia	Diabetes Type 1	HIV	Recent Weight Gain / Weight Loss
Anesthesia Complications	Diabetes Type 2	Hoarseness	Recurrent Laryngitis
Angina Pectoris	Dialysis	High Cholesterol	Rheumatic Fever
Angioplasty	Difficulty Swallowing	High Blood Pressure	Rheumatoid Arthritis
Ankle Swelling	Disc Problems	Hypothyroidism	Ringing in Ear
Anxiety	Diverticulitis	Hyperthyroidism	Seizure Disorder
Arthritis	Dizziness	Infertility	Sensation of Spinning
Asthma	Ear Infections	Irregular Heartbeat	Shortness of Breath
Atrial Fibrillation	Earaches	Jaundice	Sickle Cell Disease
Atrial Flutter	Emphysema	Kidney Disease	Sinus Trouble
Autoimmune Disorder	Endocarditis	Kidney Failure	Sinusitis
Back Pain	Epilepsy	Kidney Stone	Skin Disease
Bone Pain	Excessive Worry	Kidney Infections	Skin Tumors or Moles
Black Stools	Eye Blindness	Leg Pain with Walking	Slow Start of Urine
Bleeding Gums	Eye Injuries	Liver Disease	Slurred Speech
Bleeding Tendencies	Eye Pain	Lumps in Breast	Spinal Disorder
Blood Clots – Lung	Fast – Irregular Heartbeat	Lung Cancer	Stomach Trouble
Blood in Urine	Foot Ulcers	Mental Illness	Stroke
Blood Transfusions	Forgetfulness	MI (myocardial infarction)	SVT (supraventricular tachycardia)
Blurring vision	Fractures – Dislocation	Nausea or Vomiting	Swallowing Difficulties
Brain Tumor	Frequent Urination	Nervous Disorder	Syncope (passing out)
Breast Cancer	Gallbladder Disease	Neurologic Disorder	Tendency to be Hot / Cold
Cancer	Gallstones	Nosebleeds	Thyroid Disorder
Cataracts	Gastroenteritis	Numbness or Tingling	Thyroid Medicine or Tests
Cerebrovascular Disease	G E R D	Open Heart Surgery	Thyroid Trouble
Chest Pain or pressure	G I Bleed	Osteoarthritis	Tuberculosis
Chronic Cough	Glaucoma	Osteoporosis	Ulcer Disease
Cirrhosis	Headaches	Pacemaker Insertion	Ulcerative Colitis
Colon Cancer	Hearing Difficulties	Painful Swallowing	Urinary Tract Infection - Recurrent
Congestive Heart Failure	Heart Attack	Peripheral Vascular Disease	Valvular Heart Disease
COPD	Heart Block	Pleurisy	Varicose Veins / Phlebitis
Coronary Heart Disease	Heart Disease	Pneumonia	Vomiting Blood
Coughing Blood	Heart Failure	Previous Biopsy	Weakness on one Side
Chronic Renal Failure	Heart Murmurs	Problems with Neck	Weak /Tingling of Arms, Feet or Hands

PAST SURGICAL HISTORY

Date	Type of Surgery	Hospital / Doctor

FAMILY HISTORY

Please circle any that apply

Angina / Chest pain	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Bleeding Problems	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Cancer	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Diabetes	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
DVT (Deep Vein Thrombosis)	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Heart Attack	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Heart Surgery	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
High Blood Pressure	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
High Cholesterol	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Stroke	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6
Sudden Death	Grandmother / Grandfather / Mother / Father / Sibling x 1 2 3 4 5 6 / Children x 1 2 3 4 5 6

DFW VASCULAR GROUP

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name: _____ Date of Birth: _____

Other Names Used: _____ Social Security Number: XXX - XXX - _____

Address: _____ Phone Number: _____

City, ST, Zip_____

Date(s) of Treatment: _____

Information to be Released: _____

You are hereby authorized to release my protected health information to the following person(s)/entity:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

City, ST, Zip _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record of the above named patient.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records.

This authorization will remain in effect until otherwise specified by date, event, or condition as follows: _____

_____

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient

PAD Assessment
(Peripheral Artery Disease)

TODAY'S DATE

FIRST NAME LAST NAME DATE OF BIRTH

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

Circle YES or NO on the following questions and check all boxes that apply:

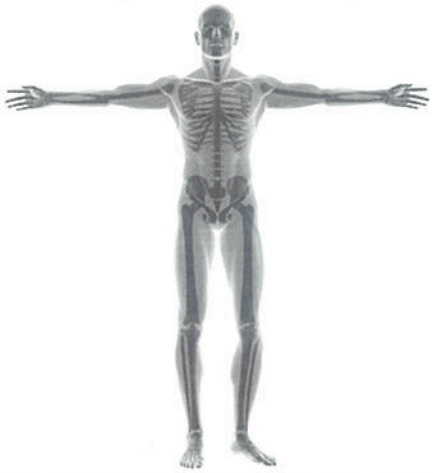
1 Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? **YES NO**

2 Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? **YES NO**
If yes, dates:_____

3 When you walk, do you experience aching, cramping or pain in your arms, legs, thighs, or buttocks? **YES NO**

4 If you answered Yes to #3, when do you feel the pain:
- ☐ After walking 1 block
- ☐ Climbing a flight of stairs
- ☐ After walking 100 yards
- ☐ Walking at increased speed

5 If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.



6 If you have pain, does the pain subside with rest? **YES NO**

7 Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? **YES NO**

8 Do you have any painful sores or ulcers on legs or feet that do not heal? **YES NO**

9 Are your legs or arms pale, discolored or bluish? **YES NO**

10 Check all that apply:
- ☐ I am a current smoker
- ☐ I have a history of smoking
- ☐ I have diabetes
- ☐ I have a family history of diabetes
- ☐ I have high cholesterol
- ☐ I have a family history of high cholesterol
- ☐ I have high blood pressure/hypertension
- ☐ I have a family history of high blood pressure/ hypertension
- ☐ I have coronary artery disease (CAD)
- ☐ I have a family history of coronary artery disease
- ☐ I have had a stroke/mini-stroke/TIA
- ☐ I have a family history of stroke/mini-stroke/TIA

DFW VASCULAR GROUP

FINANCIAL POLICIES

At DFW Vascular Group, we are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial Policy is important to maintaining that professional relationship. Please let us know if you have any questions about these policies.

INSURANCE: We participate in many insurance plans, including Medicare. Please provide your current insurance information to DFW Vascular Group. If you are not insured by a plan with which we are participating, or you do not provide valid proof of insurance and legal picture identification, a member of our staff can assist you with our self-pay rates. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We will assist you to obtain payment from any healthcare insurance policy for medical services and goods that you receive at our practice; however, you remain primarily responsible to pay for all medical services and goods that you receive from DFW Vascular Group.

VERIFICATION OF BENEFITS: We will contact your identified insurance company to determine an estimate of your financial responsibility. The amount of your financial responsibility is based on an estimate of anticipated charges. Verification of your insurance benefits is not a guarantee of payment. Your insurance benefit is a contract between you and your insurance company.

Co-payments, co-insurance and deductibles are determined by your contract with your insurance company. Co-pays will be collected at the time of your appointment with no exceptions. Your appointment may be rescheduled if appropriate payment is not made on the date of service.

REFERRALS AND PREAUTHORIZATIONS: Some insurance plans require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

COVERAGE CHANGES: To help you receive your maximum benefits, please notify us immediately if your insurance changes.

NON-COVERED SERVICES: Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. For all Medicare patients, it may be necessary to sign an ABN (Advanced Beneficiary Notice) for these non-covered services.

FILING INSURANCE CLAIMS: As a courtesy to you and upon successful verification of valid benefits, we will submit claims to your primary and secondary insurance companies. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Any patient balance is your responsibility, whether or not your insurance company pays your claim.

SELF-PAY PATIENTS: Payment is due at the time service is rendered unless other arrangements have been made in advance. Please ask to speak with a billing coordinator to discuss a payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. For your convenience, we accept most major credit cards, cash and checks.

THIRD PARTY BILLING: We do not do any third party billing. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them.

WORKERS' COMPENSATION: Not all providers at DFW Vascular Group accept Workers' Compensation Benefits. It is the patient's responsibility to provide our office staff with employer contact information, case number, date of injury and case worker contact information. If the claim is denied by the workers' compensation insurance carrier, at your request, we will submit the denied claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

MISSED APPOINTMENTS: Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

POST DATED CHECKS / RETURNED CHECKS: Post-dated checks are not accepted. The charge for a check returned for non-sufficient funds is $30.00 payable by cash or money order. You may be placed on a cash only basis following any returned check.

NON-PAYMENT: DFW Vascular Group will make every effort to work with patients experiencing financial hardships. Failure to make timely payments may result in the account being turned over to collections. Please ask to speak with a billing coordinator to discuss a payment plan.

I have read and understand the financial policies of DFW Vascular Group and agree to abide by its guidelines:

Printed Patient Name: _____ Printed Guarantor Name:_____

Patient or Guarantor Signature: _ _____ Date_____

DFW VASCULAR GROUP **NOTICE OF PRIVACY PRACTICES** **Effective 11-05-2014**

This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to DFW Vascular Group including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS. We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. We may use electronic methods of communication such as email, text messaging or other methods in order to contact you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.

- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- 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.
- To notify 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.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical 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 may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you 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 the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We 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, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below. Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We 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.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. 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 at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. 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. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number: **DFW VASCULAR GROUP, Attn: HIPAA Officer, 221 W. Colorado Blvd, Suite 625, Dallas, TX 75208, phone 214-946-5165**

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information: _____

_____

_____

Patient Name: (Please Print) _____ Patient Date of Birth: _____

Signature of Patient or Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____