Welcome to Psychiatry of Texas

Thank you for choosing us as your psychiatric care provider. Psychiatry of Texas's dedicated providers and staff are committed to ensuring that each patient receives high quality psychiatry services. This Patient Agreement establishes guidelines for your participation in treatment with us. Please read the entire Agreement and if you have any questions, please ask us.

General information and Financial Policy

All Patients

All new patients must complete our new patient documents before seeing a provider.

Emergency Services: Psychiatry of Texas is not able to provide emergency or urgent services. If you have an emergency or urgent situation, you should go to the nearest emergency room or urgent care or call 911. Email should never be used for urgent or emergency issues.

Children or Dependents: Initial evaluations for children involve a full evaluation by our providers. The purpose of this evaluation is to obtain a detailed history and perform a comprehensive examination. We may also request information from your child's other health care providers and from their school before making a working diagnosis and/or treatment recommendations. If a guardian wants to be part of their dependent's care, they must be with the child during the visit.

Adults: Initial evaluations for adults involve a full evaluation by one of our providers. We may request information from your other health care providers before making a working diagnosis and/or treatment recommendations. If any family member is involved in your care and would like to be part of your treatment and you are agreeable, the family member must be with you during the visit.

Follow-Up Sessions

Following the initial evaluation, we will discuss our assessment with you and make recommendations regarding medication(s) and/or psychotherapy. We may request lab or other tests prior to starting you on a medication. If we determine medication is appropriate for your treatment, we will schedule follow-up sessions as indicated during the treatment. In these sessions, we will monitor your response to the medication(s) prescribed and any side effects.

When your provider is unavailable for extended periods of time (i.e., vacation, conferences, etc.) another provider will provide coverage, if deemed necessary.

Speaking to a Provider outside of appointment time

If you or a family member wants to speak to a provider outside of scheduled appointment times (by phone or in-person), you will need to schedule an appointment so the provider can dedicate the time specifically for you or your family member as our providers are booked 2-4 weeks out and have patients scheduled back-to-back. If a family member needs to speak to a provider, they are expected to be with the patient during the appointment and must have the patient's consent. If patient or family needs to speak with a mental health professional and it is an emergency or a crisis, we urge you to go to the nearest emergency room or urgent care or call 911.

Regular Attendance

The relationship between you and your provider is a partnership and regular attendance at appointments is a critical part of your care. Although regularly scheduled visits with your provider may at times feel burdensome, this commitment helps assure that you receive high quality care.

Late Arrivals

If you arrive late for a scheduled appointment and your provider determines that there is not enough time remaining, your provider may request you to reschedule your appointment. If you arrive after the majority of your scheduled time for your appointment has passed, you will be considered a no-show.

No Show & Late Cancellation Policy

We reserve your appointment time specifically for you. For this reason, Psychiatry of Texas may charge a fee of $25 for no shows and appointments canceled with less than 24 hours' notice, except as may be prohibited by law or third party payers. Please also be advised that after you no show or late cancel two (2) scheduled appointments, we may consider terminating our relationship with you for non-compliance.

Children and Appointments

We kindly ask that you do not bring your children/dependents to your appointments unless they are also being seen at Psychiatry of Texas or are specifically requested to attend by your provider.

We do not permit children in our waiting area without the supervision of a parent, guardian, or caretaker.

Communication

By providing us with your phone number or email address ("Contact Information"), you understand that communication by email and text may be an insecure form of communication and you expressly consent and authorize us or our affiliates or contractors to contact you via phone calls (through the use of any dialing equipment such as artificial or pre-recorded voice technology and/or automated telephone dialing systems), text messages, and/or emails concerning your care, such as appointment reminders or payment-related messages. Messages may contain: our name or the name of your provider, location of appointment, name of patient, date and time of appointment. You have the right to revoke permission to use your Contact Information, in writing, at any time in the future.

Recording Sessions

You are not allowed to record sessions or providers/clinicians under any circumstances.

Other Appointments on the Same Day

Many insurance companies do not pay for two mental health visits on the same day. If you have visits with your psychiatrist and therapist on the same day, you may have to pay out-of-pocket for one of these visits. If you are enrolled in an in an outpatient program such as a "partial hospital program" or admitted to a hospital, your insurance may not pay for two such programs in a day and you may have to pay out-of-pocket for one of these visits.

Emergencies and Urgent Consultations

In the event of an emergency, please call 911 or go directly to the emergency room or an urgent care. Psychiatry of Texas does not provide services for an emergency or crisis. It may take us up to 5 business days to respond to questions and appointments may not be readily available. In the event of emergency or crisis, call 911 or go to the nearest emergency room or urgent care.

Forms and Documents

If you require medical and other forms to be completed for third parties, please let your provider know at the beginning of your session and your provider will discuss the completion of the forms

while they meet with you in your session. Please allow 7 to 10 business days for the completion of these forms. Generally, such forms are considered an addition to the appointment and incur a separate charge.

Disability and FMLA paperwork: To the extent permitted by law, there will be a charge of $50.00 for the completion of medical forms up to 5 pages. Any additional pages will be $15.00 per additional page, as permitted by applicable law. Charges for workers' compensation and other forms will not exceed permissible fees. In order to complete the forms, you may need to come in for an appointment. Payment is due at the time that you request these forms.

Requests for Disability

Psychiatry of Texas does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you, your provider may be willing to complete disability paperwork on your behalf, however, your provider is not required to do so and Psychiatry of Texas may assess a fee, as permitted by applicable law, to assist with such a request. Your provider may also need you to schedule a separate follow-up appointment with them for this purpose.

Requests for Substance Use Disorder Treatment

Psychiatry of Texas providers generally do not provide treatment for substance use disorders, such as treatment for detoxification, acute withdrawal, or medication-assisted treatment in an outpatient setting. Consequently, if necessary, you may be required to be admitted to inpatient treatment at a hospital. If you require substance use disorder treatment, please reach out to your insurance plan for assistance in finding an appropriate treatment provider or facility.

Hospitalizations and Hospital Patients

If your provider makes a recommendation for you to be hospitalized, you may go to the hospital of your choosing. We cannot guarantee that a bed will be available at the hospital that you may want to go to or that we may recommend. If you or your family member is at a hospital inpatient, Psychiatry of Texas may not be aware of your condition or treatment as we may not be involved with your hospital care. If you have questions about patients or family members admitted into the hospital, please contact the hospital for updates.

Medications

To ensure the best response to any prescribed medications, please observe the following:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing it with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication or stop a medication without consulting with us.
- If you need a refill before your next scheduled appointment, please call our office one week prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, canceled or missed visits can prevent you from having enough medication and make it difficult for your provider to monitor your progress and any complications.
- If you cancel or miss a visit, be sure to reschedule your next visit before you run out of medications
- If you are on controlled medications, your provider may request to see you once every month for an appointment.

Changes

Information must be updated when changes occur. It is the patient's/guardian's/power of attorney's responsibility to let us know of changes in address, phone number, email, insurance, pharmacy, etc.

Payment Policy

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan, we participate in, payment in full is expected prior to each visit. If you are insured by a plan, we participate in, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Your insurance coverage is a contract between you and your insurance company. It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage.

   We file claims with insurers as a courtesy to our patients. As a courtesy, we will also verify insurance coverage before every visit. However, the information provided by your insurance is only an estimate of your benefits; you might have a credit or a balance due to us from time to time as a result.

   To submit your claims and assist you to help get your claims processed, we must receive all the information necessary to bill. If the information is not supplied in a timely manner,

you will be billed, and payment in full will be your responsibility. If your insurance company does not pay your claim in 30 days for any reason, the balance will automatically be billed to you.

Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. The balance due for services is your responsibility without regard to whether your insurance company pays your claim.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid in full prior to the time of service. Failure on our part to collect co-payments and deductibles can be considered fraud. Please help us to comply by paying your deductibles and co-payments at each visit. If you are not able to pay your co-pay or deductible, you may be asked to reschedule your appointment, or we can refer you to a community mental health facility.

3. **Non-covered services** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full prior to the time of visit.

4. **Identification and Proof of insurance:** You agree to complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and proof of current valid medical insurance. You must provide Psychiatry of Texas with accurate and complete insurance information. You are also required to notify Psychiatry of Texas of any changes in your insurance coverage. If you fail to provide us with correct and complete insurance information in a timely manner, you may be responsible for the full cost of your treatment.

5. **Coverage changes**: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. **Nonpayment**: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you/your dependent may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. If you are not able to pay your co-pay or deductible, you may be asked to reschedule your appointment, or we can refer you to a community mental health facility.

Prior Authorizations

We are not responsible for obtaining prior authorization for medications or appointments, except as otherwise required by third party payer requirements. If a prior authorization is required for medication or if a prior authorization is required for an appointment, you may be charged $15.00, or you may be referred to a pharmacy/primary care physician who may take care of this process at no cost to you.

Returned checks

There will be a $30 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

Dismissal

If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills, or consider us to be your doctor. You will need to find a provider in another practice.

Common Reasons for Dismissal:

1. Failure to keep appointments, frequent no-shows
2. Non-compliance with treatment
3. Abusive to staff
4. We cannot provide the level of care necessary to meet your needs
5. Failure to timely pay your bills

Dismissal Process: We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you, subject to our ability to schedule an appointment. After that, you must find another doctor. We will forward a copy of your medical record to your new provider after you let us know who it is and sign a release form.

Acknowledgment of Financial Responsibility & Credit Card Authorization

You hereby assign payment of your insurance benefits to Psychiatry of Texas and authorize Psychiatry of Texas to disclose your health information to your insurance company to obtain payment for services rendered to you. You are financially responsible for all charges not covered by your insurance plan, including copays, deductibles, and balances which are due prior to the time of your visit. You agree that you may also be charged for no show and late cancellation fees incurred by you, which are due prior to the time of your visit.

You hereby authorize Psychiatry of Texas to keep your credit card information on file. You authorize us to charge your credit card for amounts owed by you. You may request receipts for credit card charges via mail or e-mail. You agree to notify Psychiatry of Texas of any changes in credit card information and will be personally responsible for the cost of care if your credit card lapses.

You understand that your Psychiatry of Texas balance due must be kept under $100 in order to continue to be seen by its providers. If you fail to timely pay your Psychiatry of Texas balances, Psychiatry of Texas may terminate providing services for non-payment.

Medicare/Medicaid Patients

If you are a Medicare or Medicaid patient, you are only financially responsible for co-pay and share of cost amounts for covered items and services.

Payment for Minor Patient

The adult accompanying a minor to their appointment is responsible for payment for services. If a minor is unaccompanied by an adult to their appointment and did not alone consent to treatment, the minor's parent/guardian is responsible for sending the minor's copayment with them.

Payment by Check

If you provide Psychiatry of Texas two (2) checks that are unable to be processed for insufficient funds, Psychiatry of Texas will no longer accept checks as a form of payment from you and you will be charged for any fees assessed Psychiatry of Texas for such invalid checks.

Past Due Balance

If you have a past due balance, you may be able to establish a payment plan with Psychiatry of Texas, with which you must comply in order to continue to be seen by your provider.

This Acknowledgement of Financial Responsibility & Credit Card Authorization will remain in effect until you provide written notice of cancellation to Psychiatry of Texas.

By signing the Consent for Treatment/Acknowledgment of Financial Responsibility & Credit Card Authorization Agreement Signature Form, you agree that you have read, agree with and understand this document, which contains information on Psychiatry of Texas' financial policies, professional fees, cancellation/no-show/late arrival, discharge policies, confidentiality, and policies regarding contacting your provider and you agree to abide by such terms during the professional relationship. You also understand and agree that our policies can change at any time and are updated on our website.

Consent to Treatment

You are voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Psychiatry of Texas for the purpose of diagnosis and treatment, and you hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by your treating provider.

You acknowledge that you understand that Psychiatry of Texas's providers include psychiatrists, psychiatric mental health nurse practitioners and Psychiatric Physician Assistants. You acknowledge that you understand that there are both risks and benefits to psychiatric treatment. You acknowledge that you are aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. You also acknowledge that you understand that while the course of your treatment is designed to be helpful, it may at times be difficult or uncomfortable. You also acknowledge that you understand that any treatment could result in side effects or adverse reactions and you hereby assume that risk when you or your dependent agree to accept treatment.

If the patient is a minor under the age of 12 and you are consenting to treatment on the minor's behalf, you must indicate your authority and sign below. You also acknowledge that that if you share legal custody of the minor patient, by signing this consent form you are representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

If you are a minor between 12 and 17 years of age, you have the right to alone consent to outpatient mental health treatment with Psychiatry of Texas and therefore you must sign this consent form to be treated by Psychiatry of Texas. However, if you require prescription

medication for your treatment, your parent or guardian is also required to sign a Consent to Medications form consenting to such prescriptions.

You acknowledge that you have had the opportunity to ask questions and all of your questions have been answered to your satisfaction. You have the right to withdraw your consent to treatment at any time.

Consent to Telemedicine

You hereby consent to the use of telemedicine by my Psychiatry of Texas provider. You understand that telemedicine involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than you. You acknowledge that you understand you have the following rights with respect to telemedicine:

Patient Choice: You have the right to withhold or withdraw your consent to telemedicine at any time without affecting your right to future treatment.

Access to Information: You understand that your telemedicine provider will communicate your relevant health information to physicians and other health care practitioners involved in your treatment who are in different offices or clinics, such as my primary care physician or therapist. Unless you object, a nonmedical technician may be present to assist with the telemedicine technology.

Confidentiality: You understand that the patient confidentiality laws apply to telemedicine, that you will not be recorded, and that no information from your telemedicine consultations which identifies you will be disclosed to third parties, except as provided in our notice of privacy practices, as amended from time to time.

Potential Risks: You acknowledge that you understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted, and stored pursuant to the telemedicine consultation. You acknowledge that you understand that telemedicine is an alternative to in-person treatment and my Psychiatry of Texas provider may recommend you discontinue telemedicine and receive in-person treatment in certain circumstances. You also acknowledge that you understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are not listed here.

Benefits: You may expect to receive benefits from telemedicine, but that no results can be guaranteed. You acknowledge that telemedicine may provide you with access to psychiatry services that otherwise would not have been available to you.

Residing in Texas: You agree to be physically resident in Texas during all telemedicine appointments.

You acknowledge that you have had the opportunity to ask questions and all of your questions have been answered to your satisfaction.

Consent to Obtain/Send Medication History

Psychiatry of Texas uses an electronic platform in its EHR to electronically prescribe medications to patients. Using this platform, providers can transmit prescriptions to a patient's desired pharmacy electronically from the point-of-care. This information helps providers to identify potential medication issues, such as drug interactions and duplicate prescriptions.

You hereby authorize Psychiatry of Texas to request and use your prescription medication history collected from other healthcare providers, third-party payers (i.e. my insurance company), and pharmacies for treatment purposes.

This Consent to Obtain/Send Medication History will remain in effect until you provide written notice of cancellation to Psychiatry of Texas.

E-Mail Authorization

You hereby request that Psychiatry of Texas and your provider, communicate with you regarding your treatment via electronic mail, or e-mail.

You understand that this means Psychiatry of Texas staff and your provider will transmit your protected health information, such as information about your appointments, diagnosis, medications, progress, and other individually identifiable information about your treatment, via e-mail. You understand there are risks inherent in the electronic transmission of information by e- mail, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered. You further understand that any protected health information transmitted via e-mail pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error free and its confidentiality may be vulnerable to access by unauthorized third parties, neither Psychiatry of Texas nor your provider shall have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the e-mail of information by Psychiatry of Texas or your provider to you.

After being provided notice of the risks inherent in the use of e-mail to transmit protected health information, you hereby expressly authorize Psychiatry of Texas and your provider to communicate via email with you, which will include the electronic transmission of your protected

health information. You understand that this E-Mail Authorization will remain in effect until you revoke it by submitting a notice to Psychiatry of Texas in writing.

You acknowledge reading and understanding the above documents and agree with them in their entirety. These include:

- General information and Financial Policy; and

- Acknowledgment of Financial Responsibility & Credit Card Authorization.

By signing this form, you consent to treatment, consent to telemedicine, consent to obtain/send medication history, and hereby authorize the transmission of your protected health information via e-mail as described above. These consents and authorizations will remain in effect until you revoke them by submitting a notice to Psychiatry of Texas in writing.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

If you are signing this Consent to Treatment as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

◯ Parent ◯ Guardian ◯ Conservator ◯ Health Care Surrogate

◯ Power of Attorney for Health care ◯ Executer / Administrator

_____ _____

Signature Date

_____

Name

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly.

We are required by law to maintain the privacy of protected health information (referred to in this Notice of Privacy Practices as "PHI," "medical information" or "health information") and to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

A. How We May Use or Disclose Your Health Information:
    1. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. Please note that we may create, receive, maintain and disclose your PHI in an electronic format. **Treatment**. We may use or disclose your PHI in order to provide, coordinate or manage your mental health treatment or services. For example, we may share your medical information with other physicians, psychologists or other health care providers who provide services to you.
    2. **Payment**. We may use and disclose PHI to obtain payment for the services we provide. For example, we might send PHI to your insurance company if required to obtain payment for services that we provide to you. We could also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process health care claims for us.
    3. **Appointment Reminders.** We may use the home/work numbers and/or email that you provide to us to make or confirm your appointments. Unless you request otherwise, our staff will leave messages at these numbers with either appointment information or requests to contact us. We may also contact you to discuss your treatment, treatment alternatives or other health-related benefits or

services we offer that may be of interest to you. *If you do not wish for us to contact you for appointment reminders or changes in appointment times, please provide us with alternative instructions (in writing).*

4. **Health Care Operations**. We may use and disclose your PHI as needed to operate our practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff.
5. **Others Involved in Your Care**. We may disclose to a family member, your personal representative or another person responsible for your care, the PHI directly relevant to that person's involvement in your care or about your location, your general condition or death. In the event of an emergency, we may disclose information to public service organizations to facilitate your care. We may also disclose information to someone who is involved with your care or helps pay for your care.
6. **Required by Law.** As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. For example, we may use or disclose PHI when the law requires us to report abuse, neglect or domestic violence, respond to judicial or administrative proceedings, respond to law enforcement officials or report information about deceased patients.
7. **Public Health**. We may and are sometimes required by law to disclose your health information to public health authorities for public health activities such as: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; and reporting to the Food and Drug Administration problems with products and reactions to medications.
8. **Health Oversight Activities**. We may, and are sometimes required by law to, disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Texas law.
9. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your PHI in the course of an administrative or judicial proceeding to the extent expressly authorized by a court or administrative order and, in certain conditions, in response to a subpoena, discovery request or other lawful process.
10. **Law Enforcement**. To the extent authorized or required by law, we may disclose your PHI to a law enforcement official for purposes such as complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correctional institution as authorized or required by law.

11. **Public Safety/National Security/Protective Services**. We may, and are sometimes required by law, to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims and for other public safety purposes. Moreover, as authorized or required by law, we may disclose your PHI for national security or intelligence purposes or to authorized federal officials so they can provide protection to the President or other authorized persons or foreign heads of state.
12. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws.
13. **Minors**. If you are an unemancipated minor under Texas law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal and ethical responsibilities.
14. **Sale of PHI**. We are prohibited from disclosing your PHI in exchange for direct or indirect remuneration unless we have obtained your prior authorization to do so.
15. **Marketing**. We must obtain your authorization before using or disclosing your PHI for marketing communications
16. **Research**: Under certain circumstances, 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.
17. **Business Associates**: There are some services provided to us or on our behalf by third parties known as "business associates". One example is the copy service we use when making copies of your health record. We may disclose your healthcare information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.
18. **With Authorization**. The following uses and disclosures will be made only with your express written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most 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.
19. **HIE**. Health Information Exchanges ("HIEs") allow health care providers to share and receive information about their patients, which assists in better coordination of patient care. We may participate in HIEs that may make your health information available to other providers, health plans, and health care clearinghouses for treatment, payment or health care operations purposes. We may also receive your health information through an HIE from other providers who have provided you with medical care. Participation in the HIEs are voluntary, and you have the

right to opt out of these HIEs at any time by completing and submitting an opt-out form to us.

20. Please note that although certain disclosures described above do not require your prior authorization under HIPAA, under Texas law we cannot make certain disclosures listed above unless you authorize the disclosure or the requesting party submits to you and us a signed, written request. Moreover, additional limitations exist with respect to our ability to re-disclose certain records that we receive from outside providers.

B. **When We May Not Use or Disclose Your Health Information**:

Except as described in this notice, this practice will not use or disclose PHI without your written authorization. If you do authorize this practice to use or disclose your PHI, you may revoke your authorization in writing at any time.

C. **Your Health Information Rights**:

1. **Right to Request Restrictions**. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit, what limitations on our use or disclosure of that information you wish to have imposed and to whom the limits should apply. Because any restrictions of your information may hinder the quality of care that we provide, we reserve the right to accept or deny such request in accordance with law. To the extent we have the right to accept or reject your request, we will notify you of our decision. If you paid in full out of pocket for a healthcare item or service, you have the right to request that we do not notify your health plan that you have obtained such items or services. In that case, we must comply with your request.
2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a post office box or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want inspect it or get a copy of it. We will charge a reasonable fee, as allowed by law. We may deny your request under limited circumstances. In such an event, we will notify you in writing of the reason for the denial, whether you have the opportunity to have the denial reviewed and if so, the process for reviewing the denial. In most cases, there is an opportunity to review the denial. We will comply with the outcome of the review.

4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about our denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. **Right to an Accounting of Disclosures**. You have a right to receive an accounting of certain disclosures of your health information made by this practice for a period of up to six years. For example, we are not required to provide you with an accounting of disclosures made to you, for treatment, payment or health care operations purposes, made with your authorization and for certain other purposes. To obtain an accounting of disclosures, you must submit your request in writing. You are entitled to one accounting within any 12-month period. If you request a second accounting in a 12-month period, we may assess a reasonable fee.
6. **Right to an Electronic Copy of Electronic Medical Records**. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee.
7. **Right to Get Notice of a Breach**. You have the right to be notified of any impermissible use or disclosure of your PHI that compromises the privacy and security of your PHI.
8. **Paper Copy**. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
9. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact us the admin@psychiatryoftexas.com.

D. Complaints:

Complaints about this notice or how this practice handles your health information should be directed to our email admin@psychiatryoftexas.com or in writing at the address below. You may also file a complaint with the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized for filing a complaint.

Attn Dr. Tai
Psychiatry of Texas
7877 Willow Chase Blvd
Houston, TX 77070

E. NOTICE CONCERNING COMPLAINTS, Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353, For more information, please visit our website at www.tmb.state.tx.us.**Changes to this Notice of Privacy Practices:**

We reserve the right to change this notice at any time in the future and the revised or changed notice will be effective for medical information we already have about you as well as any information we receive in the future. The current notice will be posted in our Practice and on our website and you may request a copy of our current notice at any time.

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

You hereby acknowledge that you have received a copy of the Practice's "Notice of Privacy Practices."

_____

Print Name of Patient

_____

Signature of Patient or Patient's Authorized Representative Date

——— OR ———

[For Office Use Only]

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

I hereby certify that, as an employee or agent of the Practice, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Practice's "Notice of Privacy Practices."

_____

Print Name of Employee/Agent and Department

_____ _____

Signature of Employee/Agent Date