Orthopedic Clinic of Galveston County

Patient Name_____ D.O.B_____ Age_____Date_____

Height:_____ Weight_____

Which BODY part are we seeing you for today?_____
(Ex. Knee, Shoulder) RIGHT or LEFT side if applicable

Describe your symptoms: (Please circle all that apply)

Weakness, Numbness, Swelling, Redness, Stiffness, Clicking, Night pain, Grinding, Popping

Other_____

Was this an injury (such as a fall, automobile accident, sports injury)?_____

Describe_____

Date of Injury_____ Was injury work related?_____

If this was NOT an injury, how long have you had these symptoms?_____

If you are having pain, please describe your pain: (Please circle all that apply)

Sharp, Throbbing, Dull, Tight, Tingling, Radiating, Burning, Other_____

Severity of pain: (On a scale of 1-10 with 10 being most severe) _____

Have you tried any of the following? (Please circle all that apply)

Ice or Heat Brace/Wrap Physical Therapy/Exercise

Have you taken any of the following medications for this condition/joint? Yes No

_____Motrin/Ibuprofen/Advil/Naproxen/Aleve
_____Voltaren/ Diclofenac
_____Tylenol
_____Aspirin
_____Celebrex/Celecoxib
_____Mobic/Meloxicam
_____Tramadol
_____Narcotics/Norco/Tylenol #3
_____Gabapentin/Lyrica
_____Other_____

Have you had an injection in this joint? Yes No

_____Cortisone/Steroid
_____Rooster Comb/ Hyaluronic Acid (Knee)
_____Stem Cell/ Amnion

If so, how many injections?_____ How long did you have relief?_____

Have you previously had surgery for this condition/joint? _____ Date_____

Are you seeing other doctors or pain management for this condition? (Who?)_____

Preferred Pharmacy: Location:

Primary Care Physician:

Current Medications:
If you have a list of your medications, please provide. If not, please fill in the list below. Include prescription, non-prescription medications and herbal supplements. If you need more room to list medications, please use the back of this page.

Name of Medication or Supplement	Dosage (i.e. Milligrams)	How often do you take it? (i.e. 1 tablet daily)

Medical Disorders: If you have had any of the following, **please circle all that apply**:

None	Stroke	Sleep Apnea
AIDS/HIV	Cancer- Breast	Gout
Alcoholism	Cancer- Colon	Heart Attack
Alzheimer's	Cancer- Lung	High Blood Pressure
Anemia	Cancer- Prostate	Hepatitis
Rheumatoid Arthritis	COPD	Kidney Disease
Asthma	Depression	Osteoarthritis
Blood Clot- Leg	Diabetes	Seizures
Blood Clot- Lung	Drug Abuse	Ulcers, bleeding
Other Disease (list below)	Blood thinners (such as Coumadin, Plavix, asprin, etc.)	

Other:_____

Past Surgical History: Please list any past surgeries

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had an adverse reaction to anesthesia?_____

Family History: Please circle all that apply

Father Medical History

AIDS/HIV
Anemia
Blood Clots
Cancer
Coronary Artery Disease
Diabetes
Gout
Heart Attack
Hemophilia
Hypertension
Kidney Disease
Liver Disease
Muscle Disease
Osteoporosis
Rheumatoid Arthritis
Osteoarthritis

Mother Medical History

AIDS/HIV
Anemia
Blood Clots
Cancer
Coronary Artery Disease
Diabetes
Gout
Heart Attack
Hemophilia
Hypertension
Kidney Disease
Liver Disease
Muscle Disease
Osteoporosis
Rheumatoid Arthritis
Osteoarthritis

Sibling Medical History

AIDS/HIV
Anemia
Blood Clots
Cancer
Coronary Artery Disease
Diabetes
Gout
Heart Attack
Hemophilia
Hypertension
Kidney Disease
Liver Disease
Muscle Disease
Osteoporosis
Rheumatoid Arthritis
Osteoarthritis

Review of Systems: If you have any of the following, **please circle all that apply**:

Constitutional
WeightLoss/Gain
Weakness
Fatigue
Fever

Cardiovascular
High Blood Pressure
Chest Pain
Rheumatic Fever
Palpitations
Has Pacemaker

Musculoskeletal
Joint Pain
Arthritis
Muscular Weakness
Stiffness
Muscular Pain

Eyes
Glasses or Contacts
Blurred Vision
Glaucoma
Cataracts
Excessive Tearing

Skin
Rashes
Sores
Lumps
Dryness
Itching

Blood or Lymph
Anemia
Easy Bruising
Easy Bleeding
Swollen Glands

Ear, Nose, Mouth, Throat
Ears Ringing
Earaches
Hearing Aid
Frequent Colds
Nasal Discharge
Hay Fever
Nosebleeds
Dentures
Bleeding Gums
Frequent Sore Throat

Neurological
Headaches
Dizziness
Seizures
Loss of Sensation
Vertigo

Gastrointestinal
Heart Burn
Rectal Bleeding
Abdominal Pain
Gallbladder trouble
Hepatitis

Respiratory
Shortness of Breath
Cough
Wheezing
Asthma
Bronchitis

Genitourinary
Blood in Urine
Urinary Infections
Kidney Stones
Burning Urination
Sexual Disease

Endocrine
Thyroid Trouble
Excessive Sweating
Excessive Thirst

Immunologic
Reactions to Drugs
Skin Rashes
Reactions to Food

Psychological
Nervousness
Depression
Mood Changes

Social History

Do you use:

Tobacco	Yes	No	Former
Alcohol	Yes	No	
Caffeine	Yes	No	
Illicit Drugs	Yes	No	

Females Only:

Could you be pregnant? Yes No

Allergies: Do you have allergies to any of the following? **Please circle all that apply**.

No known Allergies	Aspirin	
Penicillin	Amoxil	Tegretol
Codeine	Keflex	Bactrim
Sulpha Drugs	Cefzil	Pediazole
Iodine/Shellfish	Ceftin	Dilantin
Ampicillin	Suprax	Novacaine
Vantin	Septra	Insulin
Depakene	Lamictal	Lidocaine

Other Allergies:

Latex IVP/X-Ray Dye Metal Egg/Avian (Bird)

Please list any other allergies:

_____

_____

COVID 19

Have you had the COVID 19 Vaccine? _____ Date of Vaccination_____

Have you had COVID 19?_____ Date_____

ORTHOPEDIC CLINIC OF GALVESTON COUNTY
6501 MEMORIAL DRIVE, TEXAS CITY, TX 77591

Authorization to Release Information

I authorize to furnish any consulting physician, hospital, physical therapy facility, MRI facility, and/or medical supplies facility and their representatives, any information or copies of all medical records, consultations, and prescriptions relating to my illness or injury. I authorize Orthopedic Clinic of Galveston County and/or staff to furnish medical records relating to my illness or injury to my insurance company for reimbursement. A copy of this authorization shall be in effect and valid until rescinded in writing. _____ {initial)

Authorization of Insurance Benefit Payments

I authorize direct payment of medical benefits through my insurance carrier or worker's compensation carrier for services rendered. I understand that I will be billed and held responsible for any balance insurance does not pay. I understand that office deductibles, percentages, and/or co-pays are due and payable at the time of my office visit. I understand that if my condition requires surgical intervention, my insurance company will be contacted for eligibility and pre-certification. If the representative for Orthopedic Clinic of Galveston County is advised by my insurance company that I will be responsible for a percentage of the fee, I understand that I will be asked to pay this portion prior to my surgery. _____ (initial)

Authorization of Payment Responsibility

I understand that I am financially responsible for all services rendered by any Physician, staff member or any other associate while under the care of Orthopedic Clinic of Galveston County. _____ (initial)

Consent for Medical Treatment

I,_____(patient's name) knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment do hereby voluntarily consent to such procedures and care under the specific instructions of Orthopedic Clinic of Galveston County, and/or their representatives. I also acknowledge that no guarantees or warranties have been made to me with regards to the benefits to be realized or consequences of the aforementioned procedure(s)/ treatment(s). I acknowledge that X-ray films might be taken for my condition at the time of my visit and these will be viewed by the physician at his workstation. _____ (initial)

Physician Ownership Disclosure Form

This form is to disclose to you that Terry SIller, M.D. has a financial interest in Houston Physicians Hospital and Gulf Coast MRI and Diagnostic. You have a right to chose to be treated at other facilities and you will not be treated any differently by you physician, the physician's staff, or the facility. This information is being provided to you to help you make an informed decision about your healthcare. _____(initial)

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed Name of Patient or Patient's Legal Representative Relationship to Patient

Detailed Phone Messages

From time to time we will leave a message for you (as stated in our Privacy Practices) on an answering machine or voice mail. Is it ok for a message to include **details** (such as diagnosis, medication information, lab results, etc.) at this number?

☐ I **authorize** the physicians and staff of the Orthopedic Clinic of Galveston County to leave a **detailed** message on my answering machine or voice mail at these phone numbers:
- ☐ Home _____
- ☐ Cell _____
- ☐ Work_____
- ☐ Other_____

☐ I **Do Not** authorize **detailed** messages on any answering machine or voice mail.

Disclosure of Health Information

Please provide us a list of people **(husband, wife, children, other family, friends or other doctors)** we may share your Private Health Information with **(this also includes during appointment times)**. This authorization will hold in effect until you submit a written notice of any changes.

☐ I **authorize** the physicians and staff of the Orthopedic Clinic of Galveston County to release medical information (by telephone, mail or otherwise) to the following people:

_____ _____

_____ _____

☐ I **Do Not** authorize the release of medical information to my family members or friends.

Notice of Privacy Practices Acknowledgement Receipt

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. **Our Notice of Privacy Practices is available for your review in our waiting room and on our website (www.orthogalveston.com). You can also request a paper copy of our Privacy Policies at the front desk.** If you have questions, please ask to speak with our HIPAA Compliance Officer in person or by phone (409) 938-8161.

☐ I acknowledge that I have been provided a copy of Orthopedic Clinic of Galveston County Notice of Privacy Practices.

☐ I have **declined** a copy of Orthopedic Clinic of Galveston County Notice of Privacy Practices.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed Name of Patient or Patient's Legal Representative Relationship to Patient

Patient Background

CMS requires that we ask the following questions in order to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively and provide patient-centered care. Please identify which category **best describes** your Ethnicity, Race and Language.
You have the option to decline answering any category.

Ethnic Background
Hispanic or Latino
Non Hispanic or Latino
Other or Undetermined
Declined

Race
Hispanic
Asian
Caucasian
Black or African American
Native American
American Indian or Alaska Native
Other
Undetermined
Chinese
Filipino
Japanese
Native Hawaiian
Multiracial
Pacific Islander
Declined

Language
English
French
German
Vietnamese
Italian
Mandarin
Spanish
Declined

If patient is interested in conducting **future follow-up appointments** via telemedicine, please sign form.

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes. I understand that my insurance carrier will have access to my medical records for quality review/ audit.
- I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I also understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
- I understand that this document will become a part of my medical record.

By signing this form, I attest that I have personally read this form and fully understand and agree to its content; have had my questions answered to my satisfaction; and am located in the state of Texas and will be during my telemedicine visit.

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature	Date

Terry A. Siller, M.D.

Orthopedic Clinic of Galveston County
6501 Memorial Drive, Texas City, TX 77591
(409) 938-8161

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.

If you have any questions about this Notice of Privacy Practices, please contact:

Privacy Officer: Summer Cox
Phone Number: (409) 938-8161

I. Our Commitment To You

Orthopedic Clinic of Galveston County is committed to maintaining the privacy of your health information. During your treatment with us, physicians, nurses, and other personnel may collect information about your health history and your current health status. This Notice explains how that information, called "Protected Health Information" may be used and disclosed to others. The terms of this Notice apply to health information produced or obtained by Orthopedic Clinic of Galveston County.

II. Our Legal Duties

The U.S. HIPAA Privacy Law requires us to provide this Notice to you regarding our privacy practices, our legal duties to protect your private information and your rights in regard to health information about you. We are required to follow the privacy practices described in this Notice whenever we use or disclose your protected health information. Other companies or persons that perform services on our behalf (called Business Associates) must also protect the privacy of your information. Business Associates are not allowed to release it to anyone else unless specifically permitted by law. There may be other state and federal laws that we will follow that provide additional protections related to communicable disease, mental health, substance or alcohol abuse, or other health conditions.

III. Your Health Information May Be Used And Disclosed

Orthopedic Clinic of Galveston County is permitted by HIPAA Privacy Law to make uses and disclosures of your health information for purposes of treatment, payment and health care operations.

- **Treatment:** We will use and may share health information about you for your health care and treatments. For example, a nurse or medical assistant will obtain treatment information about you and record it in a medical record. Alternatively, one of our physicians may use information about you for a consultation with or a referral to another physician to diagnose your illness and determine which treatment option, such as surgery or medication, will best address your health needs. Except in emergency circumstances, we will make a "good faith effort" to get your permission prior to making disclosures outside Orthopedic Clinic of Galveston County for treatment purposes.

- **Payment:** We may use and disclose health information about you to obtain payment for the care and services that we have provided to you. We may need to provide your health plan provider with information about you, your diagnosis, and the treatment provided to you at Orthopedic Clinic of Galveston County so that your health insurer will pay us or reimburse you for the treatment. We may also contact your health insurance to obtain prior approval about a potential treatment.
- **Health Care Operations:** We may use and share health information about you for Orthopedic Clinic of Galveston County's health care operations, which include planning, management, quality assessment, and improvement activities for the treatments that we deliver. For example, we may use your health information to evaluate the skills of our physicians, nurses, and other health care providers in caring for you. We also may use your information to review quality and health outcomes. We will obtain your written permission before making disclosures to others outside Orthopedic Clinic of Galveston County for health care operations purposes.
- **Appointment Reminders:** We may use your health information to contact you by phone to confirm an appointment, or to change one, or to send you reminders of a future appointment.
- **Health-Related Benefits, Services and Treatment Alternatives:** We may also contact you about new or alternative treatments or other health care services.
- **People Assisting in Your Care:** In certain limited situations, Orthopedic Clinic of Galveston County may disclose essential health information to people such as family members, relatives, or close friends who are helping care for you or helping you pay your health care bills. We will disclose information to them only if these people need to know the information to help you. For example, we may provide limited information to a family member so that they may pick up a prescription for you. Generally, we will ask you prior to making disclosures if you agree to such disclosures. If you are unable to make health-related decisions or it is an emergency, Orthopedic Clinic of Galveston County will determine if it would be in your best interest to disclose pertinent health information about you to the people assisting in your care.
- **As Required by Law:** We must disclose health information about you if we are required by federal, state, or local law.
- **Serious Threat to Health or Safety:** We may use and disclose your health information when necessary to avert a serious threat to your health and safety, or the health and safety of the public or another person. We will only disclose your information to someone reasonable able to help prevent the threat, such as law enforcement, and when the disclosure is specifically required by law, including the limited circumstances in which Orthopedic Clinic of Galveston County's health care professionals have a "duty to warn."

IV.Special Situations In Which Your Health Information May Be Released

Your health care information may be released in the following special situations:

- **Public Health Risks:** As authorized by law, we may disclose health information about you to public health or legal authorities whose official responsibilities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths,
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products; o 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 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.

- **Organ and Tissue Donation:** Consistent with applicable law, we may release your health information to organ procurement organizations or others engaged in the transplantation of organs to enable a possible transplant.
- **Specialized Government Functions:** If you are a member of the military or a veteran, we will disclose health information about you as required by command authorities; or if you give us your written permission. We may also disclose your health information for other specialized government functions such as national security or intelligence activities.
- **Workers Compensation:** If you are seeking compensation due to a work-related injury, we may release health information about you to the extent necessary to comply with laws relating to Workers Compensation claims.
- **Employers:** We may release health information to your employer if we provide health treatment to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will provide you with written notice of such information disclosure. Any other disclosures to your employer will be made only if you sign a specific authorization for the release of that information.
- **Health Oversight Activities:** We must disclose health information to a health oversight agency for activities that are required by federal, state or local law. Oversight activities include investigations, inspections, industry licensures, and government audits. These activities are necessary to enable government agencies to monitor various health care systems, government programs, and industry compliance with civil rights laws. Most states require that identifying information about you, such as your social security number, be removed from information releases for health oversight purposes, unless you have provided written permission for the disclosure.
- **Lawsuits and Disputes:** If you are involved in a lawsuit, dispute, or other judicial proceeding, we may disclose health information about you in response to a court order or subpoena, other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may disclose your health information to a law enforcement official if required or allowed by law, such as for gunshot wounds and some burns.We may also disclose information about you to law enforcement that is not a part of your health record for the following reasons:
  - to identify or locate a suspect, fugitive, material witness, victim of a crime, or missing person;
  - about a death we believe may be the result of criminal conduct;
  - about criminal conduct at our location; and
  - in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Correctional Facilities:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official only as required by law or with your written permission. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.
- **Coroners, Medical Examiners, and Funeral Directors:** We may disclose certain health information about you to a coroner or medical examiner in the case of certain types of death. This may be necessary, for example, to make a positive identification of you or to determine the cause of your death. We may also

release the fact of death and certain demographic information about you to funeral directors as needed to carry out their duties. Other releases of your health information will require the written permission of a surviving spouse, parent, a person appointed by you in writing, or your legally authorized representative.

- **Required by HIPAA Law:** The Secretary of the Department of Health and Human Services (HHS) may investigate privacy violations. If your health information is requested as part of an investigation, we must share your information with the HHS.

V. Situations In Which Your Health Information May Be Disclosed With Your Written Consent

For any purpose other than the ones described above, we may only use or share your health information when you give us your written authorization to do so. For example, you will need to sign an authorization form before we can send your health information to your life insurance company. You may revoke an authorization at any time.

- **Marketing:** We must also obtain your written authorization before using your health information to send you any marketing materials. The only exceptions to this requirement are that (1) we can provide you with marketing materials in a face-to-face encounter or a promotional gift of very small value, if we so choose, and (2) we may communicate with you about products or services relating to your treatment, to coordinate or manage your care, or provide you with information about different treatments, providers or care settings.
- **Highly Confidential Information:** Federal and state law requires special privacy protections for certain "Highly Confidential Information" about you, including any part of your health information that is about: 1) child abuse and neglect; 2) domestic abuse of an adult with a disability; 3) mental illness or developmental disability treatment or services; 4) alcohol or drug dependency diagnosis, treatment, or referral;5) HIV/AIDS testing, diagnosis, or treatment; 6) sexually transmitted disease; 7) sexual assault; 8) genetic testing; 9) In Vitro Fertilization (IVF); or 10) maintained in psychotherapy notes. Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

VI. Your Rights Regarding Health Information We Maintain About You

- **Right to Inspect and Copy:** You have the right to inspect and/or to receive a copy of your health information that that we maintain in designated records and for which we use to make decisions about your care. If you wish to inspect and/or receive a copy of your health information, you must submit your request in writing to *Orthopedic Clinic of Galveston County, 6501 Memorial Drive, Texas City, TX 77591*. Your request must state that you want access to your health information and must be signed by you or your personal representative. We may charge you a fee for copying and postage.
- We may deny your request to inspect and/or copy your information in certain limited circumstances. For example, we may deny access if your physician believes it will be harmful to your health, or could cause a threat to others. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Orthopedic Clinic of Galveston County will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Request Amendment:** If you believe that any health information we have about you is incorrect or incomplete, you have the right to ask us to change the information. You have the right to request an amendment for as long as the information is kept by or for Orthopedic Clinic of Galveston County. To request an amendment to your health information, your request must be in writing, signed, and submitted to *Orthopedic Clinic of Galveston County, 6501 Memorial Drive, Texas City, TX 77591*. In addition, you must

provide a reason for your request. We are not obligated to make all requested amendments but we will give each request careful consideration.

- We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or location that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for us;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

- **Right to Request Restrictions on Use and Disclosure:** You have the right to request a restriction or limitation on certain uses and disclosures of your health information. To request restrictions, you must make your request in writing to *Orthopedic Clinic of Galveston County, 6501 Memorial Drive, Texas City, TX 77591*. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, if you want to prohibit disclosures for insurance payment, health care operations, for disaster relief purposes, to persons involved in your care, or to your spouse. It must be signed by you or your personal representative. *We are not required to agree to your request*, but we will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.
- **Right to an Accounting of Disclosures:** You have the right to receive an "accounting of disclosures" made by us of health information about you, as required by law. This accounting will not include any disclosures for treatment, payment, or health care operations; disclosures that you have authorized or that have been made to you; disclosures for national security or intelligence purposes; disclosures to correctional institutions or law enforcement with custody of you; disclosures that took place before April 14, 2003; and certain other disclosures. Your accounting request must be in writing and signed by you or your personal representative, and submitted to *Orthopedic Clinic of Galveston County, 6501 Memorial Drive, Texas City, TX 77591*. Your request must state a time-period for which you would like the accounting. The accounting period may not go back further than six years from the date of the request, and it may not include dates before April 14, 2003. You may receive one free accounting in any 12-month period. We will charge you for additional requests.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about health issues by alternative means or at an alternative location. For example, you may request that messages not be left on voice mail or sent to a particular address. A request for confidential communications must be in writing, signed by you or your personal representative, and submitted to *Orthopedic Clinic of Galveston County, 6501 Memorial Drive, Texas City, TX 77591*. Your request must specify how or where you wish to be contacted, and we may require you to provide information about how confidential payments will be managed. We are required to accommodate all reasonable requests.
- **Right to Receive a Copy of this Notice:** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice any time. This Notice is available at our reception desk and from our website, www.orthogalveson.com.
- **Right to Cancel Authorization to Use or Disclose:** Other uses and disclosures of your health information not covered by this Notice or the laws that govern us will be made only with your written authorization. You have to right to revoke your authorization in writing at any time, and we will discontinue future uses and

disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

VII. To File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint with us at *Summer Cox, Orthopedic Clinic of Galveston County, 6501 Memorial Drive, Texas City, TX 77591*. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. ***There will be no retaliation for filing a complaint***. We cannot, and will not, require you to waive the right to file a complaint as a condition of receiving treatment from us.

VIII. Changes to this Notice

Orthopedic Clinic of Galveston County reserves the right to amend, change, or eliminate the terms of this Notice at any time. If we change this Notice, we may make the new Notice's terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new Notice. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our reception desk and picking up a copy, or downloading one from our Web site www.orthogalveston.com

For further information: If you have questions, or would like additional information, you may contact Summer Cox, Administrator at (409) 938-8161.

Effective Date: This Notice is effective as of April 14, 2013.