Why *MyChart*?

MyChart gives you direct, online access to portions of your electronic healthcare record where your doctor stores your healthcare information. Your lab results, appointment information, medications, immunizations and more are all securely stored for quick access.

MyChart also provides easy, convenient methods for communicating with your doctor's office. Renew prescriptions, send messages, and schedule appointments - all online.

Your St. David's Heart & Vascular staff can tell you more about ***MyChart*** and help you sign up.

Your healthcare, with *MyChart*

Be an informed patient. Your healthcare is important, and asking the right questions helps you and your doctor manage your healthcare and decide on appropriate plans for your good health.

Find out how ***MyChart*** can help you stay in touch with your doctor .

For more information, or to sign up, talk to us here or visit our website listed below.

MyChart is available as an App for iPhone, iPad and Android devices. Visit the App store to download. Keyword - MyChart.

Visit us at:
https://MyChart.StDavids.com

St David's Heart & Vascular

St David's Heart & Vascular

MyChart

Your Secure Online Health Connection

Access your own, personal medical records in your own home or wherever you have Internet connection

FAQs

Is my information safe?

Yes. Our team of security experts has created a secure, encrypted connection for your ***MyChart*** site. Your security is important, and we take your security seriously.

How do I sign up?

Ask the staff at St. David's Heart & Vascular. You can also do it yourself by logging into our website at: https://MyChart.stdavids.com to complete the process online. You can also scan the QR code on the front of this brochure to visit the ***MyChart*** site.

What if I forget my user name or password?

Don't worry. Just click the "Forgot Password" link and follow the online instructions.

Can I update my information in MyChart?

There is some information you can change, such as medications you're currently taking, immunizations you received somewhere else, allergies and medical history. Your changes will be sent to your doctor for approval. There is some information that only your doctor can update. Consult your doctor if you see something that is incorrect.

Can I access MyChart on my smartphone or tablet?

Yes. Download the ***MyChart*** mobile app by visiting the app store and downloading the ***MyChart*** mobile app.

See what your doctor sees.

View your medical information online

- Review your current medications, immunizations, allergies, and medical history.
- Receive test results online - as soon as your doctor releases the results - no waiting for a phone call or letter.
- Review discharge instructions provided by your doctor.
- Review health education topics.

Manage your appointments

- Review past and upcoming appointments.
- Request, change or cancel appointments.
- Complete information online prior to your next visit. For example, complete your history, or report medication changes before your visit - all online in the privacy of your home.

Access your family's records

- Link your family's accounts to yours for convenient access to appointments, immunization records, growth charts, or information concerning your elderly parent.

Information about your procedures

- You see information on your labs, imaging tests, discharge instructions from your hospital stay.

hCare® | Epic

Stay in touch with your doctor

- Getting in touch with your doctor is as easy as sending an email - but more secure!
- Request medication renewals online.

SECURITY...

IS MY INFORMATION SECURE???

Yes. Your information is safe from unauthorized access because MyChart is password protected and delivered through an encrypted connection.

St David's Heart & Vascular

Patient Registration Form

(Please print or write legibly)

Last Name:_____First:_____MI:_____

Gender: ☑Male ☐Female Date of Birth:_____Social Security:_____

Mailing Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Please check the preferred primary phone number:

☐Home Phone: (_____)-_____☐Work Phone: (_____)-_____

☐Mobile Phone: (_____)-_____Email:_____

Preferred Language:_____ Marital Status:_____ Race/Ethnicity:_____

Emergency Contact Person:_____ Relationship: _____

Primary Number: (_____) -_____ Secondary Number: (_____)-_____

Primary Care Physician:_____ Referring Physician:_____

Employer's Name:_____ Occupation:_____

Employer's Mailing Address:_____ Suite #:_____

City:_____ State:_____ Zip:_____

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: _____/_____/_____

Secondary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: _____/_____/_____

Tertiary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: _____/_____/_____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to St. David's Heart & Vascular, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

*****Financial acknowledgement for Private Pay Patients or Patients without Insurance*****

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**

St David's Heart & Vascular

PATIENT CONSENT FORM

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a St. David's Heart and Vascular physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at St. David's Heart & Vascular, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witnessing Employee	**Employee Job Title**
Signature of Witnessing Employee	**Date**

St David's Heart & Vascular

Medication List

Patient Name:_____ Date of Birth:_____

Pharmacy:_____ Address/Location:_____ Phone number:_____

Please include all prescription and over-the-counter medications, including herbal products and vitamins. **Please update the form before every physician visit and bring the form to every visit.**

	Medication	Dose	How Often
example	*Metoprolol tartrate*	*25 mg*	*Twice daily*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Texas Heart & Vascular Review of Systems Progress Note

DATE: _____

PATIENT NAME: _____DOB:_____

PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN: _____

PHARMACY NAME: _____ PHARMACY ADDRESS: _____

PREFERRED LANGUAGE: _____ RACE: _____

ETHNICITY (CIRCLE ONE): HISPANIC OR LATINO ☐ **NON-HISPANIC OR LATINO** ☐ **OTHER OR UNDETERMINED** ☐

LAST FLU VACCINE (Month: _____Year: _____)

LAST PNEUMONIA VACCINE (only if age 65 or older) (Month: _____ Year: _____)

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? YES_____ NO_____

If "yes" and you are 65 or older please provide the following: Name_____ Phone Number_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you are currently experiencing for your visit today:

Constitution	**Eyes**	**Respiratory**	**Skin**
Fatigue ☐	Blurred vision ☐	Cough ☐	Changes in nail beds ☐
Fever ☐		Coughing up blood ☐	Poor wound healing ☐
Generalized weakness ☐	**Cardiovascular**	Shortness of breath ☐	Rash ☐
Weight gain ☐	Chest heaviness ☐	Sleep apnea ☐	Skin cancer ☐
Weight loss ☐	Chest pain ☐	Wheezing ☐	
	Chest tightness ☐		**Musculoskeletal**
HENT	Edema/Leg swelling ☐	**Endocrine**	Falls ☐
Hoarseness ☐	High blood pressure ☐	Excessive thirst ☐	Joint pain/swelling ☐
Nose bleeds ☐	High cholesterol ☐	Intolerance to cold ☐	Muscle pain/weakness ☐
	Palpitations ☐	Intolerance to heat ☐	
Gastrointestinal			**Psychiatric**
Abdominal pain ☐	**Genitourinary**	**Heme/Lymph**	Altered mental status ☐
Blood in stool ☐	Blood in urine ☐	Bleeding ☐	Anxiety ☐
Diarrhea ☐	Painful urination ☐	Easy bruising ☐	Depression ☐
Stomach pain after eating ☐	Frequent urination ☐	Swollen Lymph nodes ☐	Sleep disorder ☐
Vomiting ☐			Substance abuse ☐
Vomiting with blood ☐		**Neurological**	
		Brief paralysis ☐	
		Dizziness ☐	
		Numbness in extremities ☐	
		Seizures ☐	
		Vertigo ☐	

Please explain any other symptoms not listed above that you may be experiencing:

_____

_____

_____

☐ **DENY ALL OF THE ABOVE (if nothing has changed since your last visit, please mark this box)**

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date:** _____

ALLERGIES:

	Yes	No
Are you allergic to iodine or shellfish?	☐	☐
Have you had a reaction to x-ray contrast dye?	☐	☐
Are you allergic to any medications?	☐	☐

(If yes, please list medication names):

PAST MEDICAL HISTORY:

☐ Abnormal Heart Rhythm	☐ Cancer	☐ High Blood Pressure	☐ Sleep Apnea
☐ Anemia or Blood Disorder	☐ COPD/Emphysema	☐ High Cholesterol	☐ Stroke or TIA
☐ Anxiety	☐ Diabetes	☐ High Triglycerides	☐ Thyroid Disorder
☐ Asthma	☐ Easy bruising/bleeding	☐ HIV/AIDS	☐ Tuberculosis
☐ Arthritis	☐ Heart Attack	☐ Kidney Disorder	☐ Valvular Heart Disease
☐ Atrial Fibrillation	☐ Heart Murmur	☐ Liver Problems	☐ Varicose Veins
☐ Blood Clots veins/lungs	☐ Hepatitis	☐ Seizures	

NON-CARDIAC PAST SURGICAL HISTORY:

_____

_____

CARDIOVASCULAR TESTING & SURGICAL HISTORY:

☐ Cardiac Echocardiogram	☐ Electrophysiology Study	☐ Coronary Angioplasty (balloon)/Stents
☐ Nuclear Testing	☐ Pacemaker/ICD	☐ Valve repair or replacement
☐ Vascular Testing	☐ Bypass Surgery	☐ Stress Test
☐ Holter Monitor or Event Monitor	☐ Heart Catheterization	☐ Heart Transplant

FAMILY MEDICAL HISTORY:

	Father	Mother	Sister 1	Sister 2	Brother 1	Brother 2
Diabetes						
Heart Attack (Age <65)						
High Blood Pressure						
Living						
Stroke/CVA (Age <65)						

SOCIAL HISTORY:

TOBACCO USE: Currently smoke? ☐ Yes ☐ No Packs per day for_____years.
Previous smoker for_____years. Date/Year quit: _____

ALCOHOL USE: ☐ Yes ☐ No If yes, how many drinks per day? _____
CAFFEINE USE: ☐ Yes ☐ No If yes, how many caffeinated drinks per day?_____
DRUG USE: Have you ever used illicit drugs? ☐ Yes ☐ No if yes, year started/stopped? _____
PARTICULAR DIET ☐Yes ☐No If yes, please describe _____
EXERCISE: Yes No If yes, what type?_____How often? _____

St David's Heart & Vascular

Texas Heart and Vascular
4316 James Casey Building A&C
Austin, TX 78745
Ph: 512-623-5300 Fax: 512-623-5399

Section A: This section must be completed for all Authorizations (Texas)

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)**:**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

If this authorization is for disclosure of genetic information, please describe: _____

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

St David's Heart & Vascular

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW HEALTH 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, please contact the Facility Privacy Official by dialing the main facility number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Fundraising: We may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.*, good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research:
The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations.
Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility 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.
- **Amend:** If you feel that health 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 or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health 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. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.

- We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **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 may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICIAL
Telephone Number: (512) 206-4300 Director of Finance
7800 Shoal Creek Blvd. Suite 205N Austin, Texas 78757