PERSONAL INJURY QUESTIONNAIRE

Name _____ *Date* _____

*Address*_____ *City*_____ *State*_____ *Zip*_____

Home Phone _____ *Work* _____ *Cell* _____

SS# _____ *Sex: M F Date of Birth* _____ *Age* _____

*Email(personal)*_____ *(business)*_____

*Driver's License No.*_____ *State* ___ *Married*__ *Single*__ *Divorced*__ *Widowed*__

Employer's Name _____ *Position* _____

Spouse's Name _____ *Work Phone* _____

Nearest Relative not living with you _____ *Phone #*_____

Have you obtained an attorney? Yes ( ) No ( ) Name _____ *Phone* _____

NATURE OF ACCIDENT:

Date of Accident: _____ *Time of Accident:* _____ *AM PM*

Were you on-the-job at the time of the accident? Yes ( ) No ( )

Please explain in ***detail*** *how the accident happened* _____

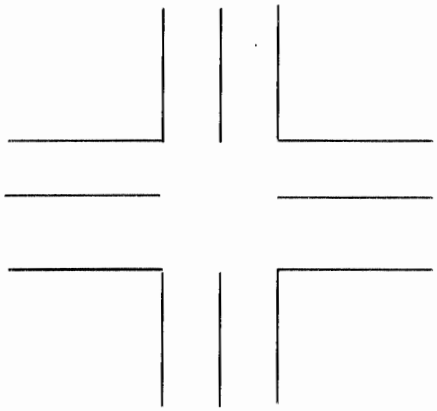
_____

_____

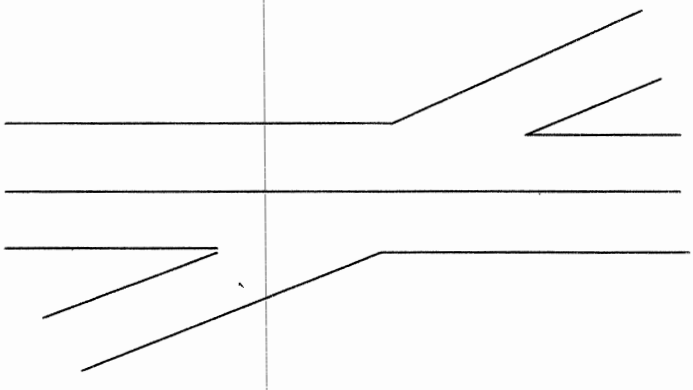
Address or intersection where accident occurred _____

Please complete the appropriate diagram of how your accident occurred. List #1 as your car and #2 as the other driver.

(Intersection diagram)



(Merge diagram)



Road conditions: Wet ( ) Dry ( ) Icy ( ) Other _____

1. *What is the year, make and model of the vehicle you were in:*_____
   Are you the registered owner of this vehicle ( ) Yes If not, who is? _____
2. *Were you: Driver ( ) Passenger ( ) Front seat ( ) Back seat ( )*
3. *Where was the damage to your vehicle? Rear ( ) Front ( ) Left side ( ) Right side ( )*
   What was the cost of damage done to the vehicle you were in? _____
4. *Did police come to the scene of the accident? Yes ( ) No ( )*
   If a ticket was issued, to whom and what for? _____
5. *Were you knocked unconscious? Yes ( ) No ( ) If yes, how long?* _____

6. *Initial symptoms immediately following the accident: ( ) None ( ) Headache ( ) Dizzy ( ) Disoriented ( ) Shock ( ) Nauseated ( ) Neck pain/stiff ( ) Mid back pain/stiff ( ) Lower back pain/stiff ( ) Numbness/tingling where _____ Other _____*

If no symptoms immediately, when did they first appear: ( )hours _____ ( )days _____ ( )weeks _____

7. *What bruises did you receive from the accident? _____*

8. *What cuts or scratches did you receive from the accident? _____*

9. *List any and all body parts that hit the interior of the vehicle during impact and what they hit.*

(Example: right knee hit dashboard, right ribcage hit armrest)_____

_____

_____

_____

_____

10. *Do your symptoms (or pain) increase when you: Cough ( ) Sneeze ( ) Walk ( ) Stand ( ) Sit ( ) Bend ( ) Lift ( ) Twist( ) At Bowel Movement ( ) ?*

11. *Where were you taken after the accident? _____By whom?_____*
Doctors name _____ Treatment/medication given _____
Were x-rays taken? Yes ( ) No ( ) Neck ( ) Low Back ( ) Mid Back ( ) Other_____

12. *What other doctor's have you been treated by and care rendered since the accident?_____*

_____

13. *Are you on **any** medication at this time? Yes ( ) No ( ) If yes, what for? _____*

_____

14. *Were you wearing a seat belt? Yes ( ) No ( ) Lap belt only ( ) Combination shoulder-lap belt ( )*

15. *Where did the top of the headrest or seatback reach: Neck or lower ( ) Bottom of skull ( ) Middle of skull ( ) Top of head or higher ( ) Not sure ( )*

16. *Were you aware of the approaching collision prior to impact, or did it catch you by surprise?*
Aware ( ) Surprise ( )

17. *Was your vehicle stopped at the time of impact? Yes ( ) No ( )*

If yes, was the driver's foot on the brake? Yes ( ) No ( )
If no, estimate the speed of the vehicle you were in: _____m.p.h.

18. *If your vehicle was moving at the time of impact, was it: Slowing down ( ) Gaining speed ( )*

Traveling at a steady rate ( ) Other _____

19. *What direction was your head positioned at time of impact?*

Forward ( ) Right ( ) Left ( ) Back ( ) Up ( ) Down ( ) Other _____

20. *What direction was your body positioned at the time of impact?*

Forward ( ) Right ( ) Left ( ) Back ( ) Other _____

22. *Before the accident, were you capable of working on an equal basis with others your age? Yes( ) No( )*
Are your work activities restricted as a result of this accident: Yes ( ) No ( )
If yes, please explain_____
Have you lost time from work since the accident? From_____ To_____

23. *Have you been involved in other accidents in the last 10 years? Yes ( ) No ( )*
Accident #1 *When? _____ What happened? _____*
What injuries were you treated for? _____
When were you released from care? _____
Accident #2 *When? _____ What happened? _____*
What injuries were you treated for? _____
When were you released from care? _____

Your car insurance (or the car in which you were injured):

Name of Insured _____ Phone _____

Insurance Co. _____ Policy # _____

Agents name _____ Phone _____

Your personal health insurance carrier:

Name of Insured _____ Relationship _____

SS# of Insured(if other than self) _____ Policy # _____

Insurance Co. _____ Phone # _____

****

Other driver's information:

1. *What is the year, make and model of the other vehicle _____*

2. *Was the other vehicle moving at the time of the collision: Yes ( ) No ( )*
Were you told how fast he/she was traveling? Yes ( ) No ( ) _____m.p.h.

3. *If the other vehicle was moving at the time of impact, do you know if it was:*
Slowing down ( ) Gaining speed ( ) Traveling at a steady rate ( ) Not sure ( )

Driver of the other vehicle _____

Name of Insured _____

Insurance Co. _____ Policy # _____

Agent's name _____ Phone# _____

****

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will immediately due and payable. If I fail to pay such outstanding charges within 90 days from my last treatment, I understand I will be responsible for any and all fees incurred in the outside collections of this account. These, but not limited to these, include court cost, attorney fees and collection agencies.

Patient's Signature _____ Date _____

Guardian's Signature (if necessary) authorizing care and payment _____

PLEASE CHECK WHICH SYMPTOMS YOU HAVE EXPERIENCED SINCE THE TIME OF THE ACCIDENT.

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

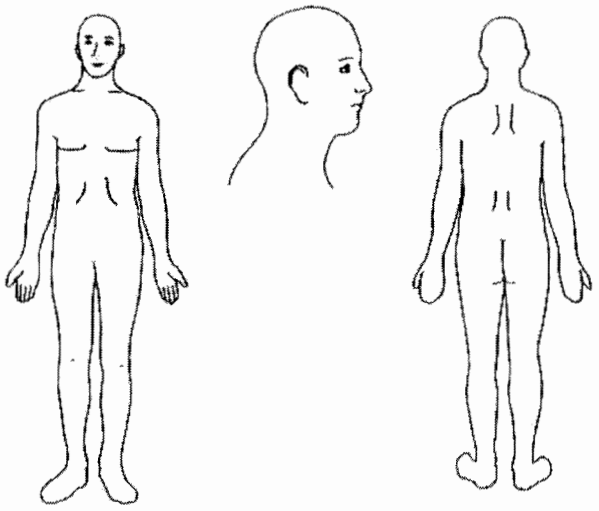
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figure below.
pain scale 1-10 (10 the worst)



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

Patient accepted? Yes_____ No_____ Doctor's signature_____

Name_____ Date_____

AUTO ACCIDENT CASE HISTORY

Please review and mark all questions to assist us with your case.

Neck and Head Pain

- Do you have neck pain? ☐ YES ☐ NO If YES, is the pain: ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- Is the pain increased with: ☐ Head movements ☐ When first get up in the morning ☐ After work ☐ When first go to bed ☐ When relaxing
- Does the pain awaken you? ☐ YES ☐ NO
- Do you have headaches with your neck pain? ☐ YES ☐ NO If YES, is the pain felt in ☐ Forehead ☐ Temples ☐ Top ☐ Right side ☐ Left side ☐ Base of skull
- Do you have memory loss? ☐ YES ☐ NO If YES: ☐ Short term ☐ Long term
- Do you have loss of concentration? ☐ YES ☐ NO
- Do you feel that you can't think of how to do your job? ☐ YES ☐ NO
- Do you have to stop & think about things you once did without thinking? ☐ YES ☐ NO
- Please explain how it has affected your home, work and/or social life

  _____
- Do you have jaw pain? ☐ YES ☐ NO If YES, is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Burning ☐ Tingling ☐ Numb
- Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- If YES, please explain_____

Arm Pain

- Do you have arm pain? ☐ YES ☐ NO If YES, is the pain: ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- Do you have arm weakness? ☐ YES ☐ NO If YES, ☐ Both arms ☐ Right only ☐ Left only ☐ Down to the elbow ☐ Down to the wrist ☐ Down to the fingers
- Do any of the following increase your arm pain? ☐ Lifting above head ☐ Head Movements ☐ Coughing ☐ Sneezing ☐ Having a bowel movement ☐ Reaching forward ☐ Reaching backwards ☐ When relaxing
- Does pain cause you difficulty using the arm? ☐ YES ☐ NO ☐ Occasionally
  If so, how?_____
- Cause you to drop things? ☐ YES ☐ NO If YES, ☐ Frequently ☐ Occasionally ☐ Almost
- Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- If YES, please explain_____

Shoulder Pain

- Do you have shoulder pain? ☐ YES ☐ NO If YES, where is the shoulder pain? ☐ Right ☐ Left ☐ Front ☐ Back ☐ Neck to joint ☐ Joint only
- Is shoulder pain : ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb

- ❖ Do any of the following increase your shoulder pain? ☐ Lifting above head
  ☐ Head Movements ☐ Reaching forward ☐ Reaching backwards ☐ When relaxing
- ❖ Were you experiencing any of these symptoms prior to the accident? ☐ YES ☐ NO
- ❖ If YES, please explain_____

Mid-Back and Chest Pain

- ❖ Do any of Do you have mid-back pain? ☐ YES ☐ NO If YES, does it hurt on the
  ☐ Right ☐ Left ☐ Middle ☐ Base of the neck ☐ Between shoulder blades
  ☐ Right shoulder blade ☐ Left shoulder blade ☐ Right ribs ☐ Left ribs
- ❖ Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- ❖ Do you have chest pain? ☐ YES ☐ NO If YES, ☐ Right ☐ Left ☐ Middle
- ❖ Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- ❖ If YES, please explain_____

Low-Back Pain

- ❖ Do you have low-back pain? ☐ YES ☐ NO If YES, does it hurt on the ☐ Right
  ☐ Left ☐ Middle
- ❖ Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- ❖ Do any of the following increase your low back pain? ☐ Coughing ☐ Sneezing
  ☐ Having a bowel movement ☐ Bending ☐ Rising from sitting ☐ Rising from bed
  ☐ When relaxing ☐ When first go to bed ☐ Walking
- ❖ Since the accident, have you had Constipation ☐ YES ☐ NO / Diarrhea ☐ YES ☐ NO
- ❖ Have you had a change in urine flow? ☐ YES ☐ NO If YES, ☐ Increase ☐ Decrease
- ❖ Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- ❖ If YES, please explain_____

Hip and Leg Pain

- ❖ Do you have pain in the hip? ☐ YES ☐ NO If YES, ☐ Right ☐ Left ☐ Front
  ☐ Back ☐ Hip joint ☐ Groin
- ❖ Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- ❖ Do you have leg pain? If YES, is the pain in: ☐ Both legs ☐ Right only ☐ Left only
  ☐ Front ☐ Back
- ❖ Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling
  ☐ Numb ☐ Down to knee ☐ Down to ankle ☐ Down to toes
- ❖ Does the leg pain make you ☐ Limp ☐ Drag your feet ☐ Shuffle
- ❖ Do any of these increase the leg pain? ☐ Walking ☐ Twisting at the waist ☐ Coughing
  ☐ Sneezing ☐ Having a bowel movement ☐ Going up steps ☐ Down steps ☐ When relaxing
- ❖ Is the pain worse ☐ Upon arising in the morning ☐ After work ☐ When lying down
- ❖ Does the leg pain awaken you? ☐ YES ☐ NO
- ❖ Do you have ankle pain? ☐ YES ☐ NO If YES ☐ Right ☐ Left
- ❖ Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- ❖ Do you have foot pain? ☐ YES ☐ NO If YES ☐ Right ☐ Left
- ❖ Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- ❖ Were you experiencing any of these symptoms prior to this accident ☐ YES ☐ NO
- ❖ If YES, please explain_____

PERSONAL INJURY ASSIGNMENT AND LIEN

(Please let us know if you need the Spanish Translation of assignment and lien)

Provider: *Stakes Chiropractic Center* ID# *74-2274227*

Address: *5400 Brodie Lane Suite 200 Austin, TX 78745-2542* Provider Type *Chiropractor*

Patient/Claimant:_____ DOB:_____ DOI: _____

Patient confirms rights to claim benefits and/or liability claims from the following Insurance Companies:

Name of Company Policy Number Type Ins. Claim Number

_____

_____

_____

ASSIGNMENT OF CONTRACTUAL BENEFITS : As a condition of receiving reasonable and necessary healthcare from the above named provider, I assign to the Provider all rights I may have under such policy to make claims and apply for and receive benefits under any insurance policy or benefit plan which I am qualified to receive, including: PIP, UM, UIM, Group Health, PPO, and HMO insurance benefits. This assignment includes and I give my power of attorney to the Provider to act on it's own, or in my name in collecting available benefits, signing payment checks, submitting information forms, and communicating, in any manner, with any insurance representative, including submission of records and billing statements as required under any insurance policy. I agree to cooperate with provider and providers representatives to collect any and all amounts owed.

CONTRACTUAL LIEN ON LIABILITY/UM/UIM INSURANCE SETTLEMENT FUNDS: In exchange for health care to be provided, I give provider named above a contractual lien on any and all funds paid from any policy of liability insurance or first party uninsured/underinsured motorists insurance as part of any settlement or advance payment, which shall be effective and enforceable immediately upon payment of any such funds. All parties to any settlement, who have notice, are responsible for protecting provider's right to be paid any unpaid balance on patient's account at the time of payment. Violation of provider's contractual lien rights may result in additional claims against all parties paying or receiving funds for conversion, misapplication of funds, and/or breach of fiduciary duty as the holder of funds protected by lien. Venue is agreed to be in the county of Provider's office in which health care has been rendered. All applicable statutes of limitations are extended for four years after provider receives written notice that a settlement payment has been made.

I have read and agree to the terms above:

Patient Signature_____ Date:_____

Parent/Legal Representative:_____Relationship:_____Date:_____

****

As authorized representative of the health provider named above, I certify a copy of this document was delivered to the following parties as follows:

Name of Party	Certified Mail Priority Mail Fax	Mail Tracking Number Or Facsimile Number	# Pages	Date Sent	Staff Initials

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500-01129 (08-05) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

STAKES CHIROPRACTIC CENTER

Dr. Douglas T. Stakes
5400 Brodie Lane, Suite 200
Austin, TX 78745-2542

Phone: 512-892-2160
Fax: 512-892-7309

Power of Attorney to Endorse Checks

Know all men by these present: That the undersigned has made, constituted, and appointed, and by these presents does hereby make, constitute and appoint Stakes Chiropractic Center and any of its' duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead, to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and said Stakes Chiropractic Center which checks, drafts, or money orders are to pay for services or the like which have been or are able to be performed by/at the requestor with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

The undersigned by these presents thus gives and grants said Stakes Chiropractic Center as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and purposes as the undersigned might or could do it personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by the virtue of these presents.

In witness whereof the undersigned have hereto set their hands, this _____ day of _____, 20___

_____
Print name of patient

_____
Signature (Parent or Guardian if child)

_____
Printed Name

_____ _____
Driver's License # State

_____
Social Security #

HIPAA Notice of Privacy Practices

Stakes Chiropractic Center 5400 Brodie Lane, Suite 200 Austin, TX 78745-2542 512-892-2160

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Other permitted and required uses and disclosures will be made only with your Consent, Authorization or Opportunity to Object unless required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including third parties. Your protected health information will be used, as needed, to obtain payment for your health care services.

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

This notice was published and becomes effective on/or before **April 14, 2003.**
You have the right to obtain a paper copy of this notice from us.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature _____ Date_____