HOUSTON VEIN SPECIALISTS
NOTICE OF PRIVACY PRACTICES/DISCLOSURE FORM

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.

OUR PLEDGE
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. This notice will tell you about the ways we may use and share medical information about you.

OUR LEGAL DUTY
We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice describing our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy policies, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For additional copies of this Notice, please contact us using the information listed at the end of the Notice.

USE AND DISCLOSURE OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment and healthcare operations. For example: **For Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. **For Payment**: We may use and disclose your health information to obtain payment for services we provide to you**. For Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations may include measuring and improving quality, evaluating the performance of employees, conducting training programs, and obtaining the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES
For Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.
For Your Family and Friends: We may use or disclose health information 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, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you the opportunity to object to such uses or disclosures. In the event of your incapacity, or emergency circumstances, we will disclose health information based in a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgement and our experience with common practice to make reasonable inferences of your best interest.
As Required by Law: We may use or disclose your health information when we are required to do so by law.
For Abuse and Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
For Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters).
YOUR RIGHTS AS A PATIENT
Access: You have the right to look at or get copies of your health information with limited exceptions. You must submit a request to this office in writing or obtain a form by calling the office number listed below. There will be a customary charge of $25.00 for the copies of records.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosures of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).
Alternative Communications: If you would like us to communicate with you about your health information by alternative means, or alternative locations, you may request this in writing.

QUESTIONS OR COMPLAINTS
If you have any questions about this notice, please contact us.
If you are concerned that your privacy may have been violated or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may file a complaint using the contact information at the end of this notice. We will also provide you with the address to file your complaint with the US Department of Health and Human Services.

Contact Information:
Houston Vein Specialists
6550 Fannin, Suite 2407
Houston, TX 77030
713-790-0000
713-790-1212 (fax)

Patient Name (Print):____Patient Signature:____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS:
I hereby authorize Houston Vein Specialists to release/request any and all medical records to referring and other physicians as my physician may deem appropriate, as well as all records necessary for the processing of Insurance claims with the following exceptions:

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I acknowledge full responsibility for the payment of each services including (co-pay, deductible, or percentage). I understand that the charges made for professional services may not be covered in full by insurance although insurance may be filed. I understand if the account becomes delinquent in payment I agree to pay full cost of collection, including reasonable attorney's fee. I authorize treatment by Houston Vein Specialists and personnel.

Signature of Patient, Parent or Agent:____Date:______________________________________