Medical Biofeedback and Pain Control Center

7515 Greenville Avenue, Suite 1005

Dallas, TX 75231

Patient Registration: ***Date:*** _____

Briefly state the medical problem for which you made this appointment today :_____

Name :_____

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

Home Phone: _____ ***Cell:*** _____ ***Work:***_____

Birth Date: _____ ***Age:*** _____ ***Social Security#*** _____ ***Sex: [ ] Male [ ] Female***

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed ***EMAIL Address:*** _____

Referred By_____ ***Phone:*** _____

Address:_____

Employment: [ ] Full-Time [ ] Part-Time [ ] Self-Employed [ ] Unemployed [ ] Retired

Employer Name & Address:_____

Occupation: _____ ***Phone:***_____

Student: [ ]NO [ ] YES, full-time [ ] YES, part-time If yes, school name: _____

Driver's License Number: _____ ***State:*** _____

Is your medical problem due to an accident? [ ] NO [ ] YES, Auto [ ] YES, Employment [ ] YES, Other

***** Date of Accident:*** _____

Name of Spouse: _____ ***SS#*** _____ ***DOB:*** _____

Employer Name & Address: _____ ***Phone:*** _____

Notify In Case of Emergency: _____ ***Phone:*** _____

Lawyer Name: (If applicable) _____ ***Phone:*** _____

(All Worker's Compensation and PPO/HMO Insurance coverage must be verified in advance)

Insurance Company: _____ ***Phone:*** _____

Address: _____ ***ID#:*** _____

Policyholder: _____***DOB:*** _____ ***Relationship:*** _____***Group #***_____

Worker's Compensation Company: _____ ***Phone:*** _____

Adjustor: _____ ***Extension:*** _____

Address: _____ ***Claim#:*** _____

WC Treating Doctor: _____ ***Phone:*** _____

Please read and sign the back of page **& please present all insurance cards to the receptionist to be copied for relevant information**

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

Payment Guidelines:
1. You must pay any co-payments, co-insurance and/or deductibles at the time of service, unless other arrangements have been made in advance with our office.
2. We accept cash, checks, money orders and credit cards (VISA, MasterCard).
3. The remainder of your bill will be sent your insurance company for payment to our office.
4. If, by mistake, your insurance company remits this payment to you, please send it to us along with all paperwork sent to you. Please do not send payment back to the insurance company.

When should you present your insurance card?
Please present your insurance card at the first visit. Specifically bring to our attention any changes (new card, new group number, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

What if your insurance company denies payment?
Sometimes your insurance company will refuse payment of a claim for some of the following reasons:
・ this is a pre-existing illness or condition that they do not cover
・ you have not met your calendar year deductible
・ the type of medical service required is not covered
・ the insurance was not in effect at the time of service
・ you have other insurance which must be filed first
・ you have exceeded your maximum dollar/visit amount

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full. We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care.

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. Both Medical Biofeedback & Pain Control Center and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law.

Patient signature: _____ Today's date: _____

<u>Insurance Authorization and Assignment:</u> Your authorization is required for our office staff to communicate with your insurance company, whether the claim is filed by the patient or by the office. Please READ and SIGN the following authorization and assignment statements:

I hereby authorize the release of any information, including medical and billing information by Medical Biofeedback to my referring doctor, insurance companies, the responsible part on my account (including lawyer's office, if applicable), and immediate family on behalf of myself and/or dependents. I permit a copy of this release to be used in place of the original.

Date: _____ Signed:_____

I hereby authorize payment of Medical benefits to Medical Biofeedback for services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amounts not covered by my insurance. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signed:_____

Release of Information: *I hereby authorize copies of my records from other medical providers to be released to Medical Biofeedback and Pain Control Center.*

Date: _____ Signed:_____

Worker's Compensation Information Release to Employer:

I hereby authorize release of medical information to my employer named below:

Name of employer: _____

Name of Supervisor: _____Phone: _____

Date: _____ Signed:_____

Payment Authorization and Release of Information to Lawyer:

I hereby authorize payment of Medical benefits to Medical Biofeedback for services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amounts not paid by my lawyer. I understand that even if my lawyer issues a Letter of Protection, I am ultimately responsible for all charges incurred. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signed:_____

No Show/Cancellation Policy:

- **We try our best to schedule your appointment at the most convenient time possible for you. However, when we have patients that do not keep their appointment times, this makes it difficult for our doctors and staff to devote the proper amount of time to our patients and ensure that treatment space is available to you. As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Cancellations must be received 24 hours in advance. Patients who do not contact us prior to their appointment will receive a no-show charge. Due to the nature of the treatment at this office, it is very important that you attend your appointments as recommended by the doctor. If the doctor has established a treatment plan of 2 visits per week, please do your best to attend as recommended.**

- **No-show charge: $50.00. This amount will be decreased to $25.00 if the appointment is rescheduled within the same week.**

- **In cases of extraordinary circumstances which do not allow you to give a one-day advance notice, you still need to call as soon as you are able and inform the clinic that you will be missing your appointment. Failure to cancel your appointment will result in being assessed a no-show appointment fee.**

Our office works hard to meet your healthcare needs and respect your time. We certainly appreciate that you trust our practice to assist you with your healthcare treatment. Please help us in providing the best possible medical care by arriving at your scheduled appointment time, calling in advance if you are unable to do so, and cancelling/rescheduling your appointments 24 hours in advance. Thank you!

I have read and understand the cancellation policy and agree to the terms.

Patient signature: _____ Today's date: _____

Medical History Questionnaire

Name: _____ Birth Date: _____ Sex: [ ] Male [ ] Female

Please fill out all requested information as accurately as possible--

General State of Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Presently under the care of a physician? [ ] No [ ] Yes, Doctor's Name: _____

Month/Year of most recent Physical Exam? _____ (mm/yy)

Month/Year of most recent Chest X-Ray: _____ (mm/yy)

List ALL current medications (prescription and non-prescription):

1. _____ 4. _____

[ ] NONE 2. _____ 5. _____

3. _____ 6. _____

List Allergies:

1. _____ Reaction _____

[ ] NONE 2. _____ Reaction _____

List ALL active health problems:

1. _____

[ ] NONE 2. _____

3. _____

List ALL traumatic events in your life: (i.e. car accident, death of a close family member, sexual or physical abuse)

[ ] NONE 1. _____

2. _____

3. _____

Major Surgeries / Hospitalizations / Emergency Room Visits:

Year Reason

[ ] NONE 1. _____ _____

2. _____ _____

3. _____ _____

List any dietary restrictions:

Restriction: Reason

[ ] NONE 1. _____ _____

GENERAL SCREENING:

CANCER	YES	NO	EXPLANATION, IF NEEDED
TUBERCULOSIS	YES	NO	
ASTHMA	YES	NO	
HEPATITIS/LIVER PROBLEMS	YES	NO	
CHRONIC COUGH	YES	NO	
MENTAL HEALTH DISORDER	YES	NO	
ANXIETY	YES	NO	
DEPRESSION	YES	NO	
HEAD TRAUMA (ANY AGE)	YES	NO	
THROMBOSIS	YES	NO	
PARALYSIS	YES	NO	
EPILEPSY	YES	NO	
IMPAIRED MOBILITY	YES	NO	
SEVERE HEARING LOSS	YES	NO	
SEVERE VISUAL IMPAIRMENT	YES	NO	
PERIODS OF UNCONSCIOUSNESS	YES	NO	
HYPERTENSION	YES	NO	
DIABETES	YES	NO	
HIGH CHOLESTEROL	YES	NO	
PROLONGED CHEST PAIN	YES	NO	
OTHER:	YES	NO	

REVIEW OF SYSTEMS:

CARDIOVASCULAR Do you currently experience…

CHEST PAIN, TIGHTNESS OF CHEST OR ANGINA ON EXERTION?	**YES**	**NO**	**EXPLAIN**
ABOVE SYMPTOMS AT REST?	**YES**	**NO**	**EXPLAIN**
NEED MORE THAN 2 PILLOWS TO SLEEP AT NIGHT?	**YES**	**NO**	**EXPLAIN**
WAKE UP AT NIGHT SHORT OF BREATH?	**YES**	**NO**	**EXPLAIN**
FREQUENT FAINTING OR DIZZY SPELLS?	**YES**	**NO**	**EXPLAIN**
DIAGNOSED WITH A HEART MURMUR?	**YES**	**NO**	**EXPLAIN**
DIAGNOSED WITH A HEART ATTACK?	**YES**	**NO**	**EXPLAIN**
HEART PALPATATIONS?	**YES**	**NO**	**EXPLAIN**

RESPIRATORY Do you currently experience…

DOES WALKING UP 2 FLIGHTS OF STAIRS MAKE YOU VERY SHORT OF BREATH?	**YES**	**NO**	**EXPLAIN**
FREQUENT YELLOW OR GREEN SPUTUM?	**YES**	**NO**	**EXPLAIN**
PHLEBITIS OR BLOOD CLOTS IN LEGS?	**YES**	**NO**	**EXPLAIN**

CENTRAL NERVOUS SYSTEM Do you currently experience…

SEIZURES	**YES**	**NO**	**EXPLAIN**
SEVERE HEADACHES	**YES**	**NO**	**EXPLAIN**
TEMPORARY CHANGES IN HEARING/VISION	**YES**	**NO**	**EXPLAIN**
TEMPORARY LOSS OF STRENGTH OR SENSATION ON ONE SIDE	**YES**	**NO**	**EXPLAIN**

GENITOURINARY Do you currently experience…

CLOUDY URINE	**YES**	**NO**	**EXPLAIN**
BLOOD IN YOUR URINE (PAST OR PRESENT)	**YES**	**NO**	**EXPLAIN**
BURNING SENSATION ON URINATION	**YES**	**NO**	**EXPLAIN**
HISTORY OF STONES	**YES**	**NO**	**EXPLAIN**
GET UP SEVERAL TIMES AT NIGHT TO URINATE	**YES**	**NO**	**EXPLAIN**
(FOR MEN) DIFFICULTY INITIATING URINATION	**YES**	**NO**	**EXPLAIN**
(FOR WOMEN) HAVE ANY GYNECOLOGICAL PROBLEMS	**YES**	**NO**	**EXPLAIN**

OTHER

DO YOU BLEED OR BRUISE EXCESSIVELY OR EASILY?	**YES**	**NO**	**EXPLAIN**
HAVE YOU EVER HAD A BLOOD TRANSFUSION?	**YES**	**NO**	**EXPLAIN**
DO YOU HAVE ANY COMMUNICABLE DISEASES?	**YES**	**NO**	**EXPLAIN**

SOCIAL HISTORY:

DO YOU SMOKE? [ ] CIGARETTES, [ ] CIGARS, [ ] PIPE	**YES**	**NO**	**HOW MANY PACKS/DAY?** **FOR HOW LONG?**
DO YOU DRINK ALCOHOL?	**YES**	**NO**	**TYPE?** **HOW MUCH?** **HOW OFTEN?**
DO YOU USE SOCIAL DRUGS?	**YES**	**NO**	**IF YES, WHAT KIND?**
DO YOU USE PRODUCTS CONTAINING CAFFEINE?	**YES**	**NO**	**HOW MANY PER DAY?**
FEMALE ONLY: ARE YOU PREGNANT?	**YES**	**NO**	**IF YES, HOW MANY WEEKS ARE YOU?**

FAMILY HISTORY:

PLEASE CHECK ALL DISEASES THAT RUN IN YOUR FAMILY:

FAMILY MEMBER AFFECTED-

- ☐ DIABETES _____
- ☐ HIGH BLOOD PRESSURE _____
- ☐ HEART ATTACK _____
- ☐ STROKE _____
- ☐ CANCER _____
- ☐ BLEEDING DISORDERS _____
- ☐ TUBERCULOSIS _____
- ☐ OTHER: _____

Patient Name: _____ Age: _____ Date: _____

Name of person completing this form (if not patient): _____

Check any issues you are having difficulty with.

ADHD Depression Anxiety Relationship
□ hyperactive □ sad □ excessive worry □ marital/significant other
□ impulsive □ sleep problems □ panic attacks □ parenting
□ under achievement □ neg. thinking □ irrational fear □ difficulty with friends
□ non-compliant □ poor concentration □ obsessions □ work/school problems
□ inattentive □ hopeless/worthless □ social isolation □ personal growth
□ poor concentration □ mood swings □ phobias □ grief/loss
□ disorganized □ guilt □ compulsive □ bullying/teasing

Anger Addictions Abuse Other
□ short-fused □ alcohol □ physical □ agitated
□ temp. tantrums □ drugs □ emotional □ mania
□ impulse control □ gambling □ domestic violence □ paranoia
□ violent/assaultive □ relationships/sex □ rape □ delusions
□ runaway risk □ eating disorders □ sexual □ tics/tourettes
□ fighting □ cyber/internet □ dissociative □ cutting behavior
□ irritable □ spending □ appetite changes
□ oppositional □ nightmares/flashbacks
□ eating disorders

Are you now or have you ever had thoughts of hurting yourself
or someone else? yes no

Past Treatment
Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? yes no

If yes, when, where, and with whom? _____
Inpatient _____ Outpatient _____
□ counselor □ psychologist □ psychiatrist □ substance abuse counselor

Did you find past treatment helpful? yes no
If yes, how? _____
If no, why not? _____

Are you currently under the care of a psychiatrist or therapist for your current problem? yes no

Are you currently taking any medications for psychiatric problems? yes no
If yes, please list: _____
_____

Do you have a history of head injury, seizures or loss of consciousness? yes no
Please explain:_____

(Women only) Are you pregnant? yes no

Substance Abuse
Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex)? yes no

Do you currently attend support groups? yes no

Circle the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants.

Have you experienced withdrawal symptoms? yes no

If yes, circle all which apply: withdrawal, headaches, nausea, vomiting, tremors, seeing things, hearing things, intoxicated.

Have you ever had a DUI? yes no

Legal Issues
Do you have current legal problems? yes no
If yes, describe: _____
_____

Are you currently on probation/parole? yes no

Do you have a DFACS worker? yes no

Employment/Education
Are you currently on leave from work or seeking medical leave/disability? yes no

Circle educational background: current student, did not complete high school, graduated high school, GED, some college, graduated college, advanced degree.

Did you experience difficulties in school? yes no

Family/Relationships
Please list anyone who lives in your home, his/her age, and relationship.
_____
_____
_____
_____
_____
_____

Does anyone in your immediate family have psychiatric, emotional, substance abuse, or behavioral problems? yes no

Is your immediate family supportive of you seeking treatment? yes no

Does anyone in your extended family have psychiatric, emotional, substance abuse, or behavioral problems? yes no
If yes, please describe:_____

Do you have any domestic violence history or current issues? yes no

. Do you have any history of sexual and/or physical abuse? yes no

Is your support network (Circle one) Good? Fair? Poor?
(i.e. friends, family, neighbors, religious organizations)
Please list: _____
_____

What are your hobbies/interests? _____
_____

Do you have difficulties or concerns about how you get
along with other people? yes no

Are you having difficulties with spiritual or religious matters? yes no

Do you have any sexual orientation/gender issues or concerns? Yes no

Treatment Access/Mobility
Are there any financial concerns that would affect your ability
to access treatment? yes no

Do you have access to transportation? yes no

Do you have any disabilities, special needs, or other restrictions
that may impact your treatment or access to treatment? Yes no

Medical Biofeedback and Pain Control Center
7515 Greenville Avenue, Suite 1005
Dallas, Texas 75231
(214) 369-8717

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
Office Manager of Medical Biofeedback and Pain Control Center.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Release of information to family/friends. With your authorization, our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

6. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
6. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
8. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
9. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **the Office Manager at Medical Biofeedback and Pain Control Center** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the **Office Manager at Medical Biofeedback and Pain Control Center**. Your request must describe in a clear and concise fashion:
- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,

- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Office Manager at Medical Biofeedback and Pain Control Center** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Office Manager at Medical Biofeedback and Pain Control Center**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Office Manager at Medical Biofeedback and Pain Control Center**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Office Manager at Medical Biofeedback and Pain Control Center**.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Office Manager at Medical Biofeedback and Pain Control Center**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Office Manager at Medical Biofeedback and Pain Control Center**.

Please sign and date the attached page.

Medical Biofeedback and Pain Control Center
7515 Greenville Avenue, Suite 1005
Dallas, Texas 75231
(214) 369-8717

Regarding HIPPA Privacy Notice to Patients:

A new government rule requires that we give you this Privacy Notice to sign. Our policy has always been to keep your records safe. Your records are usually kept in a folder of papers with your name on it. Your records can also be stored in a computer. Your records tell what treatments and tests you have had, and what decisions the doctors have made.

I, _____, have been given a copy of **Medical Biofeedback and Pain Control Center's** privacy policy to keep. I understand that my personal information will be protected under the guidelines set forth by the Health Insurance Portability and Accountability Act (HIPAA).

Patient Signature: _____

Printed Name of Patient: _____

Witness: _____

Date: _____

Medical Biofeedback and Pain Control Center
7515 Greenville Avenue, Suite 1005
Dallas, Texas 75231 (214) 369-8717

Release of Protected Health Information

Patient: _____

I authorize Medical Biofeedback & Pain Control Center to allow access to my Protected Health Information to the following:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____