EYE CONSULTANTS
OF TEXAS

Dear Valued Patient,

Your appointment at Eye Consultants of Texas is scheduled on
_______________, ________________at ____________am/pm at our **Grapevine location**.

We have enclosed patient information sheets for you to complete prior to your appointment. Hopefully, this will help expedite your time in our office. **Please do not mail these forms back to us.**

Please bring the completed forms plus your insurance card(s) and driver's license with you to your appointment. A copy will be made and kept on file with our office in order to expedite insurance billing.

Please be aware that both of your eyes may be dilated at your visit. The process for testing, diagnosing and treating your eye concerns can take up to 3 hours or more, so please plan accordingly.

Our office policy states that co-payments and or deductibles are due at the time of your visit. If you do not have insurance to cover your visit, payment will be due at the time of your visit. We accept Visa, MasterCard, American Express and Discover.

We look forward to seeing you on your appointment day. If you have any questions, please feel free to contact our office at 817-410-2030 and we would be glad to answer them for you.

Sincerely,

The Eye Consultants of Texas Team

2201 Westgate Plaza
Grapevine, Texas 76051

4932 Overton Ridge Blvd
Fort Worth, Texas 76132

EYE CONSULTANTS
OF TEXAS

Patient Registration Form

PATIENT INFORMATION: Today's Date ____________________

Last Name ______________________________ Legal First Name _____________________________ MI _________

Date of Birth ______________ Age ______ Marital Status ___________ SS# ________________ M or F (circle one)

Address ____ Apt # __________________

City _________________________ State ______ Zip __________ Email ____________________________________

Home # ________________________ Cell # _________________________ Work # ___________________________

Employer Name ___________________________________ City ________________ State ______ Zip ____________

Race ____ Ethnicity ____

Preferred Language ____

EMERGENCY CONTACT:

Name _________________________________ Relationship ______________________ Phone __________________

- Who referred you to our practice: ____
- Who is your Optometrist: ____ Phone: _________________________
- Who is your Primary Care Physician: ________________________________ Phone: _________________________
- Preferred Pharmacy: _______________________________________ (Please provide pharmacy information below)

  Street or Intersection: ____

  City: ____________________________ Phone: ___________________________

INSURANCE INFORMATION: PLEASE PROVIDE COPY OF INSURANCE CARDS TO CHECK IN

PRIMARY INSURANCE _______________________________ POLICY # _______________________________

INSURANCE PHONE # _______________________________ GROUP # _______________________________

SUBSCRIBER NAME and DATE OF BIRTH ____

SECONDARY INSURANCE ____________________________ POLICY # ________________________________

INSURANCE PHONE # _______________________________GROUP # ________________________________

SUBSCRIBER NAME and DATE OF BIRTH ____

EYE CONSULTANTS
OF TEXAS

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Medical History Questionnaire

What is the reason for your visit today?

____

____

History of <u>EYE SURGERY</u>? (Circle One) YES or NO

	Right Eye	**Left Eye**
☐ Cataract Surgery	Dates ______________________	Dates ______________________
☐ Cornea Surgery	Dates ______________________	Dates ______________________
☐ Glaucoma Surgery	Dates ______________________	Dates ______________________
☐ Refractive Surgery (LASIK, PRK, RK)	Dates ______________________	Dates ______________________
☐ Retinal Surgery	Dates ______________________	Dates ______________________
☐ Strabismus Surgery	Dates ______________________	Dates ______________________
☐ Vitreous Surgery	Dates ______________________	Dates ______________________
☐ Previous Trauma	Dates ______________________	Dates ______________________
☐ Other	Dates ______________________	Dates ______________________

<u>History of EYE DISEASES or problem?</u> (Circle One) YES or NO
(Examples: Glaucoma, macular degeneration, iritis, or dry eye syndrome) If yes, explain:

____

List of Current Drops being used: ____

<u>Do you wear contact lenses?</u> (Circle One) YES or NO If yes, are they SOFT or HARD lenses? ___________________

Family history of eye disease? (Circle One) YES or NO If yes, please explain: _________________________________

<u>Major Surgeries</u> within the last 10 yrs: ____

Social History:

Smoking:	**Alcohol:**	**Recreation Drugs:**	**Occupation:**	**Hobbies:**
☐ Current Daily Smoker	☐ Never	☐ Never	☐ Business	☐ Computers
☐ Current Occ. Smoker	☐ Rarely	☐ Rarely	☐ Manual Labor	☐ Music
☐ Former Smoker	☐ Occasional	☐ Occasional	☐ Office Work	☐ Sewing/Crafts
☐ Never Smoked	☐ Daily	☐ Daily	☐ Retired	☐ Sports
☐ Smoker, Status Unkw	☐ Frequently	☐ Frequently	☐ Student	☐ Travel
☐ Unkw if ever smoked	Heavy	☐ Heavy	☐ Teacher	☐ Golf
Type of Tobacco:	**Type of Alcohol:**	**Type of Drug:**	☐ Driver/Pilot	☐ Hunting
☐ Cigarettes	☐ Beer	☐ Amphetamines	☐ Engineer	☐ Reading
☐ Cigar	☐ Liquor	☐ Cocaine		☐ Cards
☐ Pipe	☐ Wine	☐ IV Drugs		☐ Other___________
☐ Electric Cigarettes		☐ LSD		
		☐ Marijuana		

EYE CONSULTANTS OF TEXAS

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Medication List

Please list any drug alleries:

c No Known Drug Allergies

Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:

List ALL medication you are currently taking including prescription, over the counter, as needed, vitamins, topicals and supplements.

Medication Name	Dosage and Frequency	Reason for Taking

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Review of Systems

Do you currently have any problems in the following areas? If yes, please explain.

EYES:	**GENERAL/CONSTITUTIONAL:**	**EARS/NOSE/THROAT:**
Poor Vision Pain Tearing Redness Other________________	Fever Heat Stroke Weight Loss Weight Gain Other________________	Hard of Hearing Stuffy Nose Cough Dry Mouth Other________________
CARDIOVASCULAR: High Blood Pressure Congestive Heart Failure Irregular Heart Beat Pacemaker High Cholesterol Other________________	**RESPIRATORY:** Congestion Wheezing Asthma COPD Other________________	**GASTROINTESTINAL:** Hernia Ulcers Other________________
GENITOURINARY: Impotence Enlarged Prostate Painful/Frequent urination Other________________	**FEMALES:** Pregnant Nursing	**MUSCLES/BONES/JOINTS:** Joint Pain Stiffness Swelling Cramps Arthritis Other________________
SKIN: Pimples Warts Growths Rash Other________________	**NEUROLOGICAL:** Numbness Headache Stroke Loss of Balance Other________________	**PSYCHIATRIC:** Anxiety Depression Insomnia Other________________
ENDOCRINE: Diabetes Hypothyroid Other________________	**BLOOD/LYMPH:** Bleeding Anemia Other________________	**ALLERGIC/IMMUNOLOGIC** Sneezing Swelling Redness Itching Hives Other________________

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

PAYMENT

Payment is expected at the time of service. This includes co-pays and/or deductibles if we are filing insurance for you. We accept cash, checks and major credit cards.

REFERRALS

If your insurance plan requires a referral from your primary care physician **you** are responsible for obtaining a referral **PRIOR** to your appointment. **If you do not have a referral, your appointment will need to be rescheduled.**

REFRACTION POLICY

Some insurances do not cover the refraction fee ($50.00); this will be collected at the time of service. If we file insurance other than Medicare and the refraction is not a covered benefit, you will be responsible for the fee (refractions are required annually).

CONTACT LENS FITTING

It is ECT's policy to see patients once a year in order to provide a prescription for contacts. The fee for soft contact lens fitting starts at $100.00. This includes one pair of trial contact lenses. The fee for RGP contact lens fitting starts at $200.00. RGP lenses must be ordered and are an additional cost ($120 single vision per lens, $150 bifocal per lens). **We have a limited contact lens inventory at our clinic. We are happy to refer you to one of our network Optometrist for contact lens fitting.**

WHEELCHAIR PATIENTS

If you are in a wheelchair, please inform our office ahead of time so that we can make sure we have the larger exam room available in time for your appointment. We also need to know if you are capable of getting out of your chair briefly to allow us to perform the required tests and/or exam.

MEDICAL RECORDS CHARGE

There is a $25.00 fee for copies of medical records.

RETURNED CHECK POLICY

There is a $35.00 fee for returned checks.

NO-SHOW APPOINTMENTS

Eye Consultants of Texas reserves the right to bill you for a missed or "no show" appointment without appropriate notice of cancellation.

I have read and understand the above policies.

____Patient Name

____Signature ______________Date

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Signature on File, Assignment of Benefits, Financial Agreement

___________________________________ ____________________

Patient Name (print) Medicare Number or SSN

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eye Consultants of Texas, for services furnished me by Eye Consultants of Texas. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Consultants of Texas accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services and/or items. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Consultants of Texas if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Eye Consultants of Texas may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Eye Consultants of Texas for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eye Consultants of Texas may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Eye Consultants of Texas maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Eye Consultants of Texas has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all items and/or services rendered to me by Eye Consultants of Texas if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES AND ITEMS:** I understand that Eye Consultants of Texas contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eye Consultants of Texas to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Eye Consultants of Texas I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Consultants of Texas for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient, is hereby assigned to Eye Consultants of Texas. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Consultants of Texas. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

____________ I DO NOT HAVE INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPOSIBLE FOR MY BILL.

____ ____________________________________

Patient Signature Date

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Consent For Use and Disclosure of Information

I have reviewed the NOTICE OF PRIVACY PRACTICES of Eye Consultants of Texas.
I also consent to the use or disclosure of my protected health information for the following purposes:

a) TREATMENT: **It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office, as well as other providers (including any physicians that are currently treating you).**

b) PAYMENT: Necessary information will be shared with appropriate payer sources and their representatives for payment purposes, including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

c) HEALTHCARE OPERATIONS: Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws. I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

d) DISCLOSURE OF MEDICAL INFORMATION: Please list below the names of any individuals with whom you authorize members of our office staff to discuss your medical information (example: your spouse or a parent):

1. ____

2. ____

3. ____

____ ____________________________

Patient Name (Printed) Date

____

Patient or Guardian Signature

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Patient Refund Policy

Eye Consultants of Texas strives to collect the accurate amount owed from patients for co-pays, deductibles, co-insurance and advanced technology lenses.

However, on some occasions the patient will be due a refund. In the instance of a required refund, the following policies shall apply:

- Refunds are processed for payment within 30 days of notification from the insurance provider, patient, or explanation of benefits that a refund is due to the patient.
- Refunds will be issued in the form of a paper check and mailed to the patient's last known address on file. If, however, payment was made via CareCredit, refunds will be processed through their portal in accordance with their guidelines.

I (print name) ________________________________ have read the Eye Consultant's of Texas refund policy and understand how refunds are processed.

____ _________________________

Patient or Guardian Signature Date

EYE CONSULTANTS
OF TEXAS

Today's Date: ______________________

Patient Name: ______________________

DOB: ______________________________

Patient Acknowledgement of Receipt of Privacy Practices

I (print name) ______________________ acknowledge that I have received a copy of the Eye Consultants of Texas Privacy Practices packet. I understand this is for informational and educational purposes only and it is a requirement of HIPAA guidelines that my physician's practice provides this notice to me.

____ ___________________________

Patient or Guardian Signature Date

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please read it carefully.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. We are required to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our Notice of Privacy Practices currently in effect.

1. 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 who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by aiding with your health care diagnosis or treatment with your physician.

Payment: We will use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that they will pay us for an examination or other services that we have furnished you. We may also need to inform your payer of the tests that you are going to receive in order to obtain prior approval to determine whether the service is covered.

Health Care Operations: We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for accreditation organizations, auditors or other consultants to review our practice, evaluate our operations, and tell us how to improve our services.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:
Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.
Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.
Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your

eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.
Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.
Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.
Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.
Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if

you have questions about access to your medical record.
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 health care 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 your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.
You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. The right to receive this information is subject to certain exceptions, restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS. If you have any complaints concerning our Privacy Policy, you may contact the Secretary of the department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 (email: ocrmail@hhs.gov). You may also contact us at the address provided at the bottom of this notice.
To obtain a copy of this notice or obtain more information about the Notice of privacy Practices, you may contact our Privacy Officer at:

Eye Consultants of Texas
Attn: Privacy Officer
2201 Westgate Plaza
Grapevine, TX 76051
817-410-2030

This notice was published and becomes effective on April 28, 2020.