WELCOME!

We value each of our patients like family and strive for the most professional, compassionate care possible! Lifecare Family Medicine Clinic feels excellence in all we do is our goal! Please take a moment to familiarize yourself with our practice guidelines and services.

INSURANCE
We accept most major medical insurance and, of course, are happy to file your claim for you, electronically in most cases. We try to be sensitive to each individual's situation and particular needs. Co-pays and deductibles are part of your agreement with your insurance carrier, and must be collected on the date of service.

Due to the rising cost of malpractice insurance, office expenses and so forth, medical expenses continue to skyrocket. Lifecare is aware of this and makes his best attempt to keep costs down, still provide the intensity of service needed, and bill appropriately. If you receive a bill from our office you do not understand or want to question an item, please call the office to discuss it. We will make every effort to work with extreme financial hardship cases in regard to outstanding account balances.

SCHEDULING
We make every effort to insure timely appointments. Most of the time, we will be able to see you the same day you call. Please reserve this "last minute" type of appointment for just that. For ongoing medical needs, long term health problems and such, we ask that you please schedule these appointments well ahead of time.

We reserve additional appointment slots in the summer months (June, July, and August) for wellness exams (physicals). We do perform annual female exams, men's physicals, adolescent school and camp physicals, so plan to get this done in the summertime. This keeps you out of a waiting room full of cold and flu as well.

If for any reason, you cannot keep your appointment, please call as soon as you realize this so that we can reschedule a more convenient time. We really do try to maximize appointment availability for all of our patients. Also, if you have waited more than 15 minutes in the waiting room, please tell the receptionist, as there has probably been an oversight. We are sensitive to your schedule, and hope you'll be sensitive to ours, too.

REFERRALS/CONSULTATIONS
If Lifecare feels you need to see a specialist, we will make every effort to get you in as soon as possible. One of our staff will attempt to get approval from your insurance company (if necessary) and call you with an appointment within 5 business days. In urgent cases, we will do this much sooner, often within 24 hours, as needed. Please be patient when referrals take a bit longer! Most of the time we are able to notify you of your appointment within a day or two. Patients who feel they need referral to a specialist for a particular illness need to be seen by Lifecare before we can make that referral for you.

ALTERNATIVE MEDICINE
Dr. Gerstenberg is interested in getting you the care you need in the safest, most economical way possible. As such, he is always open to those who are open to using alternative therapies. Lifecare is trained in osteopathic manipulation (similar to chiropractic care) and utilizes nutritional approaches to everything from Attention Deficit/Hyperactivity Disorder to fibromyalgia to irritable bowel syndrome and migraines. Just ask if you are interested. Certain pains (like chronic daily headaches, shoulder, knee and leg pain) are readily addressed with a pain treatment system right here in the office. Ask for details.

PROCEDURES
We do perform many minor procedures you may not be aware of. While many women prefer to go to their OB/GYN for annual checkups, Lifecare is very capable of doing this wellness exam – often a lot sooner than the OB/GYN can! Minor skin bumps, like moles, warts, and corns, can be treated or removed right here in our office. Many parents choose to have their well baby care and routine immunizations done here as well.

PRESCRIPTIONS
Call the pharmacy for your refills and they will contact us. No prescriptions will be refilled if you have not been seen in the office within six months. There will be NO narcotic medication refills after hours or on the weekend/holidays. When you call with a question, Lifecare will personally address each need, or he may direct the staff/nurses on what to tell you over the phone. If necessary, we may need you to come in to be seen in the clinic.

Tell others if you like the service you get. Tell US if you don't – so we can try to make things right !

Lifecare Family Medicine Clinic
2200 Highway 365
Nederland, TX 77627

Phone: 409-722-4321
Fax: 409-722-1221
www.lifecarefamily.com

Lifecare Family Medicine Clinic

K. Paul Gerstenberg, D.O. Chad W. Hammett, M.D.

PEDIATRIC PATIENT INFORMATION SHEET

PLEASE PRINT THE FOLLOWING INFORMATION

Please complete this form and return it along with your insurance card to the front desk.

Date: _________________ ***Race:____________ ***Ethnicity:___________________ Date of Birth: _______________

Last Name: _________________________ First: _____________________________ Middle: _________________

Gender: M or F SSN:_____________________ Preferred Language: _______________________

Marital Status: S M W D Phone: ____________ Work: _____________ Cell:__________________

Email:_______________________________________

Patient Reminder Preference: email___Patient Portal___Mail___Telephone___(work or home)

Address: ____

____

Zip Code: _____________ City: _________________________________ State: _____________

Guarantor: Self or _________________DOB_______ SS#: _____________Relationship:_________________________

Is guarantor address same as patient Yes/No____

Employment Status: Employed Retired Unemployed Other:____

Employer: ____

Address: ____Zip: ____________________________

Employer Phone #: ____

Insurance Name: ____

Group #: ________________ Policy #: _________________Ins phone #:_____________________________________

Second Ins Name: ________________________________ Insured: ____

Group # ____ Policy #: ____

If group policy, employer: ____

Emergency Contact: First Name: ___________________________ Last: ______________________________________

Relationship: __________________ Gender: M or F

Home phone #: ________________________ Work #: _____________________ Cell #: _________________________

Preferred pharmacy: _______________________________Location:____

I give consent to treatment for myself for any type service deemed medically necessary. I shall be responsible to pay for any professional services received. I realize that insurance billing is performed as a courtesy and is no guarantee of payment for services. I authorize payment to be made directly from the insurance company to the physician and any medical records released top process my claim.

Signature Patient or Guarantor: __________________________________ Date: ________________

Witness: ____ Date: ________________

How did you hear about us? Word of Mouth Yellow Pages Other:___________________________

Revised 10/7/2010

Due to U.S. Government mandates and Meaningful Use effective January 1, 2011, our office is required to collect information regarding race and ethnicity.

Race:

African American
Alaska Native
American Indian
Asian
Caucasian
Hispanic
Native Hawaiian
Pacific Islander
Other (please specify)

Ethnicity:

Afghani
African
American
Arab
Asian
Australian
Belgian
Black
Brazilian
British
Canadian
Chinese
Creole
Czech
Dutch
Egyptian
European
Filipino
French
German
Greek
Guatemalan
Hawaiian
Hungarian
Indian
Indonesian
Iraqi
Irish
Israeli
Jamaican
Japanese
Korean
Mexican
North American Indian
Pakistani
Polish
Russian
Scottish
Slovak
Spanish
Swedish
Thai
Turkish
Vietnamese
Other (please specify)

Lifecare Family Medicine Clinic
K. Paul Gerstenberg, D.O., P.A.
Chad W. Hammett, M.D., PLLC
2200 Hwy 365 Nederland, TX 77627
409-722-4321 Fax 409-722-1221

PATIENT CONSENT FOR RELEASE OF HEALTH INFORMATION (MEDICAL RECORDS RELEASE AUTHORIZATION)

With my consent, please send a copy of my medical records to Lifecare Family Medicine Clinic. Lifecare Family Medicine Clinic's office will only use my medical records/protected health information for usual medical care and or services. Please refer to Dr. Gerstenberg and Dr. Hammett's Notice of Privacy Practices for a more complete description of such uses and disclosures.

Patient Name: ______________________________

Social Security #: ____________________ Date of Birth: ____________________

Street Address: ______________________________

City, State & Zip: ______________________________

I hereby request release of my medical record from:

Provider Name: ______________________________

Provider Address: ______________________________

Provider Phone #: ____________________ **Provider** Fax #: ____________________

Please **circle** which applies:
To furnish a copy of: **My Complete Medical Records** **Office notes, medication history & correspondence**
Lab and blood test results **X-ray and Other diagnostic test results**
Other______________________________

To: Lifecare Family Medicine Clinic **Tel (409) 722-4321**
2200 Highway 365 **Fax (409) 729-2332**
Nederland, Texas 77627

With this consent, I authorize release of my medical record, as indicated above. I hereby release your physicians and employees from liability associated with the release of this information. I understand this information has been disclosed to me from records whose confidentiality is protected by Federal Law. I understand federal regulations prohibit me from making any further disclosure of this information except with written consent of the patient. This authorization will expire 90 days from the date of my signature. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

______________________________ ____________________ ____________________
Signature of patient OR legal guardian Relationship to Patient Date

______________________________ ______________________________
Name of patient (**Please Print**) Name of parent/guardian (if applicable) (P**lease Print**)

Name: ____ **Date:** ______________

Pediatric Past Medical History

Circle any that apply (please specify)

None
Allergies (food/pollen)
Asthma
Attention Deficit Disorder
Chickenpox/Eczema (skin rashes)
Fracture (s)_________________________________
Frequent ear/sinus infections
Pneumonia
Headaches
Seizures
Mental Retardation
Heart Disease _______________________________
Lung Disease _______________________________
Stomach/Intestine ____________________________
Kidney/ Bladder ______________________________
Muscle/Bones _______________________________
Thyroid/Diabetes _____________________________
Neurological/Brain ____________________________
Blood Disorder_______________________________
Anemia/Sickle Cell Trait
Immune Disorder
Cancer _____________________________________
Other ______________________________________

Surgeries

None
Tonsils
Appendix
Other ____________________________________
____

Please ✓the
Members of Household

__ Parents __ Mother __ Father
__ Step Mother __ Step Father
__ # Brothers __# Sisters
__ Maternal grandparents
__ Paternal grandparents
__ other (specify) __________________________
____
____

___ Daycare ___ School

Tobacco Smoke exposure __ yes __ no
13 ↑ Do you smoke __yes __no
DRUG ALLERGIES
____
____
____

Please ✓ all that apply.	Mother	Father	Maternal Grand-Mother	Maternal Grand-Father	Paternal Grand-Mother	Paternal Grand-Father
Heart Attacks						
High Blood Pressure						
Diabetes						
Stroke						
Cancer (Please Specify)_____________						
Thyroid Problems						
High Cholesterol						
Sudden Death						
Other						

List all Medications Currently Taking:____
____

Immunization History: up to date Yes No
Have you brought a copy of the patient's immunization history? Yes No

Lifecare Family Medicine Clinic
2200 Hwy 365
Nederland, TX 77627

New Patient Questionnaire

(this must be completed, if not it will delay scheduling of appointment)
Print or write legibly/continue on back of page if needed

1. Have you been treated/being treated for back pain and or you currently taking medication for this condition? If yes, explain and list doctors previously seen and identify medication.

2. Do you suffer from chronic headaches? If yes, explain and list doctors previously seen and identify medication.

3. Have you been diagnosed with anxiety/depression? If yes, explain your treatment and list doctors previously seen and list medication.

4. Have you been diagnosed with ADD/ADHD? If yes, explain and list doctors previously seen and list medication.

Lifecare Family Medicine Clinic reserves the right to dismiss any patient who fails to fill this form out completely and then later during the examination reveals any of the above conditions.

Patient Signature:_________________________Date:__________________________

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **Lifecare Family Medicine Clinic** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Lifecare Family Medicine Clinic** to**:**

Determine the pharmacy benefits and drug co-pays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

____ ____________________

Patient Name (PRINTED) Date of Birth

____ ____________________

Patient/Guardian Signature Date

Payment Policy **Please Print Name:____**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in abiding by the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You need to pay for these services at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We need a copy of your driver's license and current valid insurance to provide proof of insurance. If we do not have the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payment arrangements may be made with the billing office when there is a financial hardship. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may need to be dismissed from this practice. If this happens, you will be notified (by regular and certified mail), that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis
8. **Missed appointments.** Our policy is not to bill for missed appointments. If a patient "no shows" repetitively, we may elect to dismiss them from the practice. Please help us to serve you better by keeping your regularly scheduled appointment, or cancel in a reasonable amount of time so we may fill that appointment with someone else who needs to be seen.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

If you like something about our service, tell others. If you don't, tell us!

I have read and understand the payment policy and agree to abide with it:

____ ________________________

Signature of patient or responsible party **Date**

Lifecare Family Medicine Clinic

K. Paul Gerstenberg, D.O.

Chad W. Hammett, M.D.

Release of Billing and Medical Information

When your family member or friend calls for billing or medical information for you, we need their name listed on file in order to release the information. Please be sure they have your date of birth for reference. If the date of birth is not given to, we will be unable to release any information over the phone.

Billing:

I give my authorization to release billing information to: (Please limit to two individuals)

Name:_________________________ **Name:**___________________________________
(Please print) **(Please print)**

Relationship:___________________ **Relationship:**_____________________________

Medical:

I give my authorization to release medical information to: (Please limit to two individuals, can be same as above.)

Name:________________________ **Name:**____________________________________
(Please print) **(Please print)**

Relationship:__________________ **Relationship:**______________________________

Patient Name (Please Print):____

Patient Signature:__________________________________**Date:**___________________

Lifecare Family Medicine Clinic

K. Paul Gerstenberg, D.O., P.A
Chad W. Hammett, M.D.

Notice of Insurance Card Policy

Dear Patient,

In order to keep billing costs down and continue to provide you with comprehensive medical care, we would like to inform you of our policy on filing insurance. It is our policy to obtain a copy of your current insurance at time of service. This will enable us to file on the correct insurance for your visit. In the event you do not give us your insurance card and we file on the wrong insurance or if we file on your insurance and find it has terminated, you will be responsible for the cost of your services and will be expected to pay in full immediately on advisement of insurance notification to our office.

If you do not present your insurance card at time of service, you will be required to sign and date this notice as proof we have informed you of this policy. Thank you in advance for your understanding and co-operation in this matter.

K. Paul Gerstenberg, D.O.   Chad W. Hammett, M.D.

____   ______________________________
Patient or Guardian   Date

Lifecare Family Medicine Clinic

Immunization Policy for 2010

We will no longer be administering routine pediatric immunizations. We recommend you make arrangements with the county health department to receive desired immunizations.

However, we will continue to administer the following:

Tetanus (Td)

Seasonal Flu Vaccine

Pnuemovax for adult pneumonia

Thank you,
K. Paul Gerstenberg, D.O.

1/1/2010

Lifecare Family Medicine Clinic

K. Paul Gerstenberg, D.O.

Chad W. Hammett, M.D.

Notice of Privacy Practices Receipt

I was encouraged to read Lifecare Family Medicine Clinic's **Notice of Privacy Practices** available on the Clinic's web site (www.lifecarefamily.com). I am aware that I may inquire of the Clinic's staff any questions I may have pertaining to their Privacy Practices.

____
Signature of Patient or Guardian
Date:______________________________

1Chad W. Hammett, M.D.

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 (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 are also required by law to provide you with a 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 these laws are complicated, but we must provide you with the following 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 in the past, and for any of our records that we may create or maintain in the future, our practice will post a current copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Chad W. Hammett, M.D.
2200 Hwy. 365
Nederland, Texas 77627
(409) 722-4321

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (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 test (such as blood or urine test), and we may 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 to order to treat you or to assist others in 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 the billing and collection efforts.

3. Health Care Options.

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. Treatment Options.

Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives

6. Health-Related Benefits and Services.

Our practice may use and disclose your HPI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends.

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 the babysitter to take their child to their pediatrician. This person would receive PHI due to the fact that they were taking care of the child.

8. 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 DISCLOSURES OF YOUR PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use if we 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
- 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 agencies and authorities regarding the potential abuse or neglect
- An adult patient (include domestic violence); however, we will only disclose this information if the patient agrees or we are required/authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to work place injury or illness or medical surveillance.

2. Health Oversight Activities.

Our practice may use and disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensor 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 may also 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 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 your PHI if asked to do so by law enforcement officials**:**

- **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 office**
- **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 victims(s) of the crime, or the description, identity, or location of the perpetrator).**

5. Deceased Patients.

Our practice may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation.

Our practice may release your PHI to organizations that handle organs, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ tissue donation and transplantation if you are an organ donor.

7. Research.

Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except when** an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

- **An adequate plan to protect the identifiers from improper use and disclosure;**
- **An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by the law);**
- **Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) (1)for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted (2) the research could not practicably be conducted without the waiver(3)the research could not practicably be conducted without access to and use of the .**

8. Serious Threats to Health and Safety.

Our practice may use and disclose your HPI when necessary to reduce or prevent a 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.

9. 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**.**

10. National Security.

Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. 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 **(c)** to protect your health and safety of other individuals.

12. Workers Compensation.

Our practice may release your PHI for Workers Compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR

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. In order to request a type of confidential communication, you must make a written request to **Chad W. Hammett**, **D.O. 2200 Hwy 365 Nederland Texas 77627 409-722-4321** 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 options. Additionally, you have the right to request that we restrict our disclosure of your PHI to certain individuals involved in your care or the payment for your care, such as family members and/or 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 a written request to our office and describe the request in a clear and concise fashion.

- **the information you wish restricted**
- **whether you are requesting to limit our practice's use, and 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 our office 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 us for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for an amendment. Our practice will deny your request if you fail to submit(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;**

©) not part of the PHI which you would be permitted to inspect and copy; (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 disclosure our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares 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 our office. 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 the additional lists within the same 12 month period. Our practice will notify you of the costs involved with the additional request, and 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 please contact our office.

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 it must be submitted in writing. **You will not be penalized for writing 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 use regarding the use and disclosure of 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 card.

If you have any questions regarding this notice or our heath information privacy policies, please contact us;

Chad W. Hammett, M.D.
2200 Hwy 365, Nederland, Texas 77627
409-722-4321

1**K. Paul Gerstenberg, D.O.**

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 (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 are also required by law to provide you with a 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 these laws are complicated, but we must provide you with the following 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 in the past, and for any of our records that we may create or maintain in the future, our practice will post a current copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

K. Paul Gerstenberg, D.O.
2200 Hwy. 365
Nederland, Texas 77627
(409) 722-4321

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (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 test (such as blood or urine test), and we may 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 to order to treat you or to assist others in 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 the billing and collection efforts.

3. Health Care Options.

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. Treatment Options.

Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives

6. Health-Related Benefits and Services.

Our practice may use and disclose your HPI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends.

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 the babysitter to take their child to their pediatrician. This person would receive PHI due to the fact that they were taking care of the child.

8. 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 DISCLOSURES OF YOUR PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use if we 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
- 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 agencies and authorities regarding the potential abuse or neglect
- An adult patient (include domestic violence); however, we will only disclose this information if the patient agrees or we are required/authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to work place injury or illness or medical surveillance.

2. Health Oversight Activities.

Our practice may use and disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensor 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 may also 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 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 your PHI if asked to do so by law enforcement officials**:**

- **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 office**
- **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 victims(s) of the crime, or the description, identity, or location of the perpetrator).**

5. Deceased Patients.

Our practice may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation.

Our practice may release your PHI to organizations that handle organs, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ tissue donation and transplantation if you are an organ donor.

7. Research.

Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except when** an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

- **An adequate plan to protect the identifiers from improper use and disclosure;**
- **An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by the law);**
- **Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) (1)for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted (2) the research could not practicably be conducted without the waiver(3)the research could not practicably be conducted without access to and use of the .**

8. Serious Threats to Health and Safety.

Our practice may use and disclose your HPI when necessary to reduce or prevent a 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.

9. 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**.**

10. National Security.

Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. 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 **(c)** to protect your health and safety of other individuals.

12. Workers Compensation.

Our practice may release your PHI for Workers Compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR

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. In order to request a type of confidential communication, you must make a written request to **K. Paul Gerstenberg**, **D.O. 2200 Hwy 365 Nederland Texas 77627 409-722-4321** 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 options. Additionally, you have the right to request that we restrict our disclosure of your PHI to certain individuals involved in your care or the payment for your care, such as family members and/or 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 a written request to our office and describe the request in a clear and concise fashion.

- **the information you wish restricted**
- **whether you are requesting to limit our practice's use, and 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 our office 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 us for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for an amendment. Our practice will deny your request if you fail to submit(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;**

©) not part of the PHI which you would be permitted to inspect and copy; (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 disclosure our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares 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 our office. 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 the additional lists within the same 12 month period. Our practice will notify you of the costs involved with the additional request, and may withdraw your request before you incur any costs.

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