SOUTH TEXAS VASCULAR INSTITUTE
STVI

2511 Cornerstone Blvd., Ste. 2511
Edinburg, TX 78539
(956) 322-7662

Patient's Name: _____
Last Middle First

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____Ext._____

DOB: ____/_____/_____ Gender: □ Male □ Female Social Security #: _____-_____-_____

Email Address: _____ Primary Source of Contact: □ Home Phone □ Cell Phone

Driver's License #:_____ Employer: _____ Work Phone #: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Whom May we call in Case of an Emergency? Name: _____ Relationship to Patient: _____

Primary Phone #: _____ Secondary Phone #: _____

Referring Physician: _____ Physician's Phone #: _____

Collection Policy: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect co-payments, co-insurance and deductibles at time of service. Once a balance reaches 90 days old without payment, it may be transferred to a third party for further collections or other actions. Due to the quantity and complexity of forms requested, there will be a $10.00 charge, payable in advance, for the completion of each of the first two forms requested. There will be a charge of $25.00 for all subsequent forms.

Canceling/Rescheduling An Appointment: If you are unable to keep your appointment, please notify our office at least twenty-four hours in advance to cancel or reschedule your appointment. Your courtesy will allow other patients needing exams the option to use your scheduled appointment time. Patients will be charged $25 for missed appointments unless the appointment was cancelled 24 or more hours in advance. Worker's Compensation patients will be personally responsible for this amount.

Patient's Initials: _____

***Primary Insurance Co.**: _____ Insurance Phone #: _____

Insured Name: _____ DOB: ____/_____/_____ SSN: _____-_____-_____

Patient Relationship to Insured: _____

Insurance ID #: _____ Group #:_____

***Secondary Insurance Co.:** _____ Insurance Phone #: _____

Insured Name: _____ DOB: ____/_____/_____ SSN:_____-_____-_____

Patient Relationship to Insured: _____ Insurance ID #: _____ Group #: _____

Consent for Purpose of Treatment, Pay Healthcare Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information **South Texas Vascular Institute, PLLC**, hereby referred to as **STVI**, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of South Texas Vascular Institute, PLLC. I understand that diagnosis or treatment of me by **STVI and/or other providers that are employed or contracted with STVI** may be conditioned upon my consent as evidence by my signature on this document. I understand that **STVI and/or other providers that are employed or contracted with South Texas Vascular Institute, PLLC** may provide care to me in facilities in which they may have a financial interest.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. STVI is not required to agree to the restrictions that I may request. However, if STVI agrees to a restriction that I request, the restriction is binding on South Texas Vascular Institute and

_____.

(Patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that **South Texas Vascular Institute, PLLC** has taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review STVI's Notice of Privacy Practices prior to signing this document. The South Texas Vascular Institute Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of STVI. The Notice of Privacy Practices for STVI is also available at the front desk of each clinic. This Notice of Privacy Practices also describes my rights and the STVI duties with respect to my protected health information.

STVI reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

DISCLOSURE AND CONSENT

Medical and Therapeutic Procedures

To the patients: You have the right, as a patient, to be informed about your condition and the recommended therapies to be used so that you may make the decision whether or not to undergo the treatment after knowing the risks and hazards involved.

_____ ***Initial***

Consent to Treat: I understand that as a patient I have the right to make all decisions regarding my care. I voluntarily request _____ as my treating Physician, and such associates, as a Physician Assistant/Nurse Practitioner, RN/LVN, technical assistants and other health care providers as deemed necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cure. I understand that my Physician and/or Physician Assistant may discover other or different conditions which require additional or different procedures than those planned. I authorize my Physician and/or Physician Assistant to perform such other procedures which are advisable in their professional judgment.

Specific Surgical/Diagnostic Procedures: _____

_____

_____ ***Initial***

Risk and Emergency: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the treatment. I understand my risk and also **(DO / DO NOT)** consent to the use of blood, blood products, anesthesia, in cases of emergency.

_____ ***Initial***

Authorization to Release Information: I authorize South Texas Vascular Institute to release any and all healthcare information as necessary to (a) obtain payment from my Payers for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment or prognosis; it will also include where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV or the diagnosis of AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, that my blood may be tested for the HIV antibody and other communicable diseases.

_____ ***Initial***

Financial Authorizations: I authorize all payers to pay directly South Texas Vascular Institute for services provided. I assign to South Texas Vascular Institute my right to receive payment from third party payers. Third Party payers include anyone from whom benefits are, or may become payable to me for services provided.

_____ ***Initial***

Receipt of Information: I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients Rights, Responsibilities and Healthcare Choices" from South Texas Vascular Institute. I certify this for has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ ***Initial***

Financial Responsibilities: I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I agree to pay these charges including payments not paid by my insurance company payers within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all requests of my insurance company within a timely manner to ensure payment is made with in 120 days. I understand that if I am covered by Medicare / Medicaid, my obligation under this section may be limited by law.

_____ ***Initial***

Property: I understand that South Texas Vascular Institute does not assume responsibility for any personal property.

_____ ***Initial***

No Show/ Late Appointment Policy: I understand that 24 hours notice is required for appointment cancellations and that cancellations can and must be left on voicemail if after hours. Without 24 hours notice, I understand and agree to a $15 nurse no show fee, $25 standard sick appointment no show fee, or $50 Well exam or procedure no show fee. All no show fees are to be collected prior to the next scheduled appointment or before services are rendered. After 3 No Shows on record, we reserve the right to conclude our relationship for noncompliance of stated office policy. If you are more than 15 minutes late for your scheduled appointment, you will need to reschedule your appointment. The practice runs on a tight schedule in order to provide the best care for all in a timely manner.

_____ ***Initial***

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufactures in conjunction with product education. We do not receive direct financial compensation from any of our vendors. By initialing here, you acknowledge this disclosure.

PATIENT/ OTHER LEGALLY RESPONSIBLE PERSON (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents.

Signature: _____ Date and Time: _____

Witness: _____

Name: _____ Relationship _____

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VASCULAR INSTITUTE
STVI

2511 Cornerstone Blvd, Ste. 2511
Edinburg, TX 78539
P: 956-322-7662 F: 956-338-5709

Authorization to Release or Obtain Medical Records

I, _____ DOB: _____Authorize:
Patient's Name (Please Print)

☐ **South Texas Vascular Institute**
2511 Cornerstone Blvd, Ste. 2511
Edinburg, TX 78539
(P) 956-322-7662 (F) 956-338-5709

Or Other (specify below)

☐ Name of Person or Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

☐ **To release information to:** ☐ **To Obtain information from:**

Name of Person of Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

Purpose of this Authorization: _____
I authorize the release of the following protected health information:
(Place an "X" in the box(es) that apply to this information you want released or want to obtain)
For personal copies of your medical records the cost will be $25.00 for the first 25 pages and .25 cents for each page thereafter. Please allow 15 business days from day of request to process your request for medical records.

☐ Entire record ☐ Consultation notes/report ☐ Lab reports ☐ X-Ray reports ☐ Surgical reports

☐ Medical History, Examination reports ☐ Treatment or Test ☐ Hospital records including reports

☐ Other: _____

Patient Signature: _____ Date: _____

Witnessed by: _____Date: _____

Name: _____ **Date:** _____

DOB: _____

PAST MEDICAL HISTORY

PLEASE LIST ALL OF YOUR MEDICAL PROBLEMS, SUCH AS HIGH BLOOD PRESSURE OR HEART DISEASE

_____

_____

PLEASE LIST ALL OF YOUR PAST SURGERIES, HOSPITALIZATIONS, SEVERE INJURIES (INCLUDE DATE)

_____

_____

_____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? _____

LIST MEDICATIONS THAT YOU ARE **CURRENTLY** TAKING (INCLUDE NAME & DOSAGE)

_____

_____

_____

SOCIAL HISTORY

WHAT KIND OF WORK DO YOU DO? _____

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED

DO YOU HAVE CHILDREN? ____ YES ____ NO HOW MANY? _____

WHO LIVES AT HOME WITH YOU? _____

DO YOU DRINK ALCOHOL? ____ YES ____ NO IF YES, HOW MAY DRINKS PER WEEK _____

DO YOU USE ILLICIT DRUGS? ____ YES ____ NO DESCRIBE: _____

DO YOU SMOKE? ____ YES ____ NO IF YES, HOW MANY PACKS PER DAY _____ FOR HOW LONG _____

DO YOU EXERCISE REGULARLY? ____ YES ____ NO DESCRIBE: _____

DO YOU FOLLOW A SPECIAL DIET? ____ YES ____ NO DESCRIBE: _____

FAMILY HISTORY

MEMBER ALIVE/DECEASED AGE HEALTH STATUS/CAUSE OF DEATH

FATHER: _____

MOTHER: _____

SIBLING: _____

OTHER INFORMATION:

HEIGHT _____ WEIGHT _____

DO YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH ANY OF THE FOLLOWING?
(CHECK ALL THAT APPLY)

CONSTITUTIONAL	**SKIN**	**HEMATOLOGIC/BLOOD**	**EYES**
____RECENT WEIGHT LOSS	____PSORIASIS	____BLOOD CLOTS	____WEARS GLASSES
____RECENT FEVERS	____ECZEMA	____ANEMIA	____CATARACTS
GENITOURINARY	**ENDOCRINE**	**EAR/NOSE/THROAT**	**PSYCHIATRIC**
____PROSTATE	____DIABETES	____SINUS PROBLEMS	____DEPRESSION
____KIDNEY PROBLEMS	____THYROID	____ACTIVE DENTAL PROBLEMS	____SCHIZOPHRENIA
CARDIOVASCULAR	**GASTROINTESTINAL**	**NEUROLOGIC**	**RESPIRATORY**
____ HEART ATTACK	____COLITIS	____SEIZURES/EPILEPSY	____ASTHMA
____HEART MURMUR	____DIVERTICULITIS	____POLIO	____BRONCHITIS
____IRREGULAR HEARTBEAT	____ULCER	____PARKINSONS DISEASE	____EMPHYSEMA
____HIGH BLOOD PRESSURE	____ HERNIA	____ALZHEIMERS DISEASE	____PNEUMONIA
____HIGH CHOLESTEROL	____LIVER DISEASE	____BALANCE PROBLEMS	____TUBERCULOSIS

MUSCULOSKELTAL	**CANCER**	**OTHER**
____RHEUMATOID ARTHRITIS	WHAT KIND/TREATMENT	_____
____ANKYLOSING SPONDYLITIS	_____	_____
____LUPUS	_____	_____
____OSTEOPOROSIS	_____	_____

IN GENERAL, WOULD YOU SAY YOUR HEALTH IS ____EXCELLENT ____VERY GOOD ____FAIR ____ POOR

DOES YOUR HEALTH NOW LIMIT THESE ACTIVITIES?

MODERATE ACTIVITIES: MOVING A TABLE, PUSHING A VACCUM CLEANER, BOWLING OR PLAYING GOLF

____YES, VERY LIMITED ____YES, SLIGHTLY LIMITED ____ NO, NOT LIMITED AT ALL

DURING THE PAST 4 WEEKS, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOU WORK OR OTHER REGULAR DAILY ACTIVITIES AS A RESULT OF YOUR PHYSICAL HEALTH?

ACCOMPLISHED LESS THAN YOU WOULD LIKE? _____YES _____NO

DIDN'T DO WORK OR OTHER ACTIVITES AS USUAL _____YES _____NO

DURING THE PAST 4 WEEKS, HOW MUCH DID PAIN INTERFERE WITH YOUR NORMAL WORK, INCLUDING HOUSE WORK AND WORK OUTSIDE OF THE HOME?

_____ NOT AT ALL _____ SLIGHTLY _____ MODERATELY _____QUITE A BIT _____EXTREMELY

THE FOLLOWING QUESTIONS RELATE TO HOW YOU HAVE FELT DURING THE PAST 4 WEEKS.

HOW MAY TIEMS DURING THE PAST 4 WEEKS HAVE YOU?

FELT CALM AND PEACEFUL? ___ALWAYS____MOST OF THE TIME ____SOMETIMES ____NONE OF THE TIME

HAD A LOT OF ENERGY? ___ALWAYS____MOST OF THE TIME ____SOMETIMES ____NONE OF THE TIME

FELT DEPRESSED? ____ALWAYS ____MOST OF THE TIME ___SOMETIMES ____NONE OF THE TIME

DURING THE PAST 4 WEEKS, HOW MUCH OF THE TIME HAS YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS AFFECTED YOU VISITING FRIENDS, RELATIVES, ETC.?

____ ALWAYS ____ MOST OF THE TIME ____ SOMETIMES ____ NONE OF THE TIME

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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.

If you have any questions about this Notice, please contact:

South Texas Vascular Institute, PLLC

WHO WILL FOLLOW THIS NOTICE?

- South Texas Vascular Institute, PLLC providers
- All South Texas Vascular Institute, PLLC employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at South Texas Vascular Institute, PLLC, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

South Texas Vascular Institute, PLLC shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

- South Texas Vascular Institute, PLLC will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.

- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.

- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses, and disclosures are necessary to run South Texas Vascular Institute, PLLC in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.

- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, South Texas Vascular Institute, PLLC may provide a written or telephone reminder that your next appointment is coming up.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved

through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

    - To prevent or control disease, injury, or disability;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
    - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

  - In response to a court order or subpoena; or
  - If South Texas Vascular Institute, PLLC determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.

- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for South Texas Vascular Institute, PLLC If you request a copy of the information, South Texas Vascular Institute, PLLC may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

South Texas Vascular Institute, PLLC may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by South Texas Vascular Institute, PLLC will review your request and denial. The person conducting the review will not be the person who denied your request. South Texas Vascular Institute, PLLC will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask South Texas Vascular Institute, PLLC to amend the information. You have the right to request an amendment for as long as the information is kept by South Texas Vascular Institute, PLLC.

  To request an amendment, your request must be made in writing and submitted to South Texas Vascular Institute, PLLC In addition, you must provide a reason that supports your request.

  South Texas Vascular Institute, PLLC may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, South Texas Vascular Institute, PLLC may deny your request if you ask us to amend information that:

  - Was not created by South Texas Vascular Institute, PLLC unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by South Texas Vascular Institute, PLLC;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list, you must submit your request in writing to South Texas Vascular Institute, PLLC's office manager. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. South Texas Vascular Institute, PLLC will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information South Texas Vascular Institute, PLLC uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information South Texas Vascular

Institute, PLLC discloses about you to someone who is involved in your care or the payment for your care.

South Texas Vascular Institute, PLLC is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which South Texas Vascular Institute, PLLC has been paid out of pocket in full. Should South Texas Vascular Institute, PLLC agree to your request, South Texas Vascular Institute, PLLC will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to South Texas Vascular Institute, PLLC. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit South Texas Vascular Institute, PLLC's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that South Texas Vascular Institute, PLLC communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that South Texas Vascular Institute, PLLC contact you only at work or by mail.

  To request that South Texas Vascular Institute, PLLC communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. South Texas Vascular Institute, PLLC will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with South Texas Vascular Institute, PLLC or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with South Texas Vascular Institute, PLLC, contact the Privacy Officer at 956-322-7662. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing; ***You will NOT be penalized for filing a complaint.***