PATIENT REGISTRATION FORM/PARAGON PAIN & REHABILITATION, LLP

**Today's Date: _____/_____/_____ Clinic Location: _____ DALLAS PARIS _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____

*Employer Name and Address: _____

_____ Work Phone #: (_____) _____-_____

Cell Phone #: (_____) _____-_____ Home Phone #: (_____) _____-_____

Emergency Contact Name: _____ Emerg Phone #: (_____) _____-_____

EMAIL ADDRESS WE MAY CONTACT YOU AT: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Paragon Pain & Rehabilitation, LLP or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Paragon Pain & Rehabilitation, LLP is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Paragon Pain & Rehabilitation ,LLP or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Paragon Pain & Rehabilitation, LLP Patient Information Privacy Policy. I hereby authorize Paragon Pain & Rehabilitation, LLP or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Paragon Pain & Rehabilitation ,LLP representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to resend this authorization at any time by notifying Paragon Pain & Rehabilitation, LLP to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason. Urine Drug Screen testing is billed by lab and may be out of network.

Use of the email info@paragon-ppr.com to communicate with office staff, this is not an encrypted email. No privacy should be assumed. This email is only answered during open office hours by staff.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Paragon Pain & Rehabilitation, LLP physician or his or her designee. I consent to download of pharmacy information from Sure Scripts clearinghouse or DPS Pat system.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

Paragon Pain & Rehabilitation, LLP
Norberto Vargas, M.D. PA JP Benavides, D.O. Melanie Albert, FNP Erica Rush, ACNP-BC Tim LaVoy, PC-C
PO Box 1200 Colleyville TX 76034 Phone: (972) 203-3600 Fax (972) 203-3601
Web Site www.paragon-ppr.com

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

GENERAL CONSENT/DISCLOSURE INFORMATION

Patients who are part of our pain management practice are often scheduled for procedures such as diagnostic and therapeutic procedures. These procedures include, but are not limited to, electrodiagnostic studies, epidural injections, selective nerve root blocks, facet joint injections, botulinum toxin injections, trigger point injections, viscosupplementation injections, prolotherapy injections, and peripheral joint injections, ABI testing, and PRP. Your doctor will discuss with you which specific procedures you may undergo prior to receiving any intervention. These procedures can be diagnostic as well as therapeutic. Ultrasound guidance may be used to improve outcome of joint injection in office. I consent to the use of Ultrasound guidance by physician.

Medical procedures of any sort, even a simple flu shot, carry inherent risk. These risks include bleeding, infection, and pain with the injection, no pain relief, allergic reaction, tissue injury, avascular necrosis, osteoporosis, paralysis, death, and others. These more serious complications are rare, but are a possibility. The risk of bleeding is increased with the use of blood thinners such as aspirin, coumadin/warfarin, Plavix, and nonsteroidal anti-inflammatory agents such as Aleve, Advil/Ibuprofen, and others.

These injections are sometimes done under x-ray guidance called fluoroscopy to ensure the medication is placed in the correct location. **If fluoroscopy is used, you must inform your physician if you are, or potentially can be pregnant.** A routine pregnancy screen may be requested, Injected radioopaque dyes may be used to help identify your anatomy. **You must inform your doctor of any allergies to medications, iodine, latex, or shellfish prior to injection.**

I have discussed with my doctor and understand the potential risks of the procedures provided by Paragon Pain & Rehabilitation, LLP and any other alternative care my doctor feels is appropriate for my condition. I give permission to have these procedures performed as part of my evaluation and treatment. In addition, I certify this form has been explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

SUBXONE PATIENT'S WILL BE REQUIRED TO UNDERGO PSYCHOLOGICAL COUNSELING.
ALL PATIENT M AY BE REQUIRED TO UNDERGO PSYCHOLOGICAL COUNSELING.

*PROLO THERAPY is not approved by the FDA, the Food and Drug Administration. The FDA is the federal agency that approves medications for use on humans in the United States. In addition, Dr. Benavides or Vargas has told me that I do have other options or choices to treat my condition. These options have been discussed and are documented in providers date of service dictation. _____ (patient initial *.*

UDS testing is a required test for our pain management patients. The lab we use may be out of network of your insurance plan. Discuss with Urine Collector if you have a concern. UDS is not billed by our practice it is outside lab.

$50.00 Missed Procedure Fee and New Evaluations will be charged on all missed procedures, canceled, rescheduled less than 48 hours of appointment and certainly for all no show procedure appointments. _____ (patient initial) *

I agree that Paragon Pain & Rehabilitation may download my medication history from PMP system and the Surescripts Pharmacy Clearinghouse. I understand that this medication history my reflect prescription medications prescribed to me by doctors not employed with this practice and such information will be used in my care and treatment.

Signed: _____ _____
Patient Signature Date

Signed: _____ _____
Physician Signature/Witness Date

Revised 11/15/2018

PARAGON PAIN & REHABILITATION, LLP
Physical Medicine and Rehabilitation
Norberto Vargas, M.D. PA JP Benavides, D.O.
P. O. Box 1200 Colleyville, TX 76034
Phone: 972 203-3600 Fax: 972 203-3601
Web Site www.paragon-ppr.com

FINANCIAL RESPONSIBILITY AGREEMENT

PATIENT NAME: _____ DOB: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____ **Date:** _____
(please sign here – Patient or Responsible Party)

Responsible Party Name: _____
(please print name of Responsibility Party if different from Patient)

Payment due at Time of Service.

PAIN SCALE 0-10:

0 PAIN FREE

1 VERY MINOR ANNOYANCE; OCCASIONAL MINOR TWINGES.

2 MINOR ANNOYANCE; OCCASIONAL STRONG TWINGES.

3 ANNOYING ENOUGH TO BE DISTRACTING.

4 CAN BE IGNORED IF YOU ARE REALLY INVOLVED IN YOUR WORK, BUT STILL DISTRACTING.

5 CAN'T BE IGNORED FOR MORE THAN 30 MINUTES.

6 CAN'T BE IGNORED FOR ANY LENGTH OF TIME, BUT YOU CAN STILL GO TO WORK AND PARTICIPATE IN SOCIAL ACTIVITIES.

7 MAKES IT DIFFICULT TO CONCENTRATE, INTERFERES WITH SLEEP. YOU CAN STILL FUNCTION WITH EFFORT.

8 PHYSICAL ACTIVITY SEVERELY LIMITED. YOU CAN READ AND CONVERSE WITH EFFORT. NAUSEA AND DIZZINESS SET IN AS FACTORS OF PAIN.

9 UNABLE TO SPEAK. CRYING OUT OR MOANING UNCONTROLLABLY; NEAR DELIRIUM.

10 UNCONSCIOUS. PAIN MAKES YOU PASS OUT.

ROS	YES	NO	N/A
CONSTITUTIONAL: GENERAL/HEAD			
Symptom: no known problems			
Symptom: weight loss			
Symptom: fever			
Symptom: chills			
Symptom: fatigue			
Symptom: generalized weakness			
Symptom: facial pain			
Symptom: facial swelling			
Symptom: pain in temples			
EYES: EYES			
Symptom: no known problems			
Symptom: blurred vision			
Symptom: eye pain			
Symptom: redness			
Symptom: watering			
Symptom: light sensitivity			
Symptom: itching			
Symptom: conjunctivitis			
ENT: EARS, NOSE, THROAT			
Symptom: no known problems			
Symptom: earache			
Symptom: fullness of ears			
Symptom: hearing problems			
Symptom: ringing in ears			
Symptom: sinus drainage			
Symptom: sinus problems			
Symptom: nasal problems			
Symptom: nose running			
Symptom: difficulty swallowing			
Symptom: dry throat			
Symptom: tender glands			
CARDIOVASCULAR: HEART			
Symptom: no known problems			
Symptom: chest pain			
Symptom: palpitations			
Symptom: fainting			
Symptom: murmurs			
Symptom: edema			
RESPIRATORY: RESPIRATORY			
Symptom: No known problems			
Symptom: shortness of breath			
Symptom: shortness of breath with exertion			
Symptom: wheeze			
Symptom: lightness			
Symptom: cough			
GASTROINTESTINAL: GASTROINTESTINAL			
Symptom: no known problems			
Symptom: abdominal pain			
Symptom: nausea			
Symptom: vomiting			
Symptom: constipation			
Symptom: diarrhea			
Symptom: blood/tarry stools			
Symptom: heartburn/reflux			
GENITOURINARY: URINARY SYSTEM			
Symptom: no known problems			
Symptom: difficulty starting stream			
Symptom: difficulty voiding			
Symptom: flank pain			
Symptom: frequency			
Symptom: no urine production for 8 hours			
Symptom: painful urination			
Symptom: bladder accident			
Symptom: stress incontinence			

ROS	YES	NO	N/A
MUSCULOSKELETAL: MUSCULOSKELETAL			
Symptom: no known problems			
Symptom: joint pain			
Symptom: muscle pain			
Symptom: back pain			
Symptom: leg cramps			
NEUROLOGY: NEUROLOGIC			
Symptom: no known problems			
Symptom: numbness/tingling			
Symptom: dizziness			
Symptom: seizure			
Symptom: altered mental status			
Symptom: dementia			
Symptom: focal weakness			
Symptom: headaches			
Symptom: memory impairment			
Symptom: tics			
ENDOCRINOLOGY: ENDOCRINE			
Symptom: no known problems			
Symptom: excessive thirst or urination			
Symptom: heat/cold intolerance			
Symptom: change in hair texture			
Symptom: increased appetite			
HEMATOLOGY/LYMPHATIC: HEMATOLOGIC			
Symptom: no know problems			
Symptom: easy bleeding			
Symptom: bruising			
Symptom: swollen glands			
Symptom: anemia			
Symptom: swollen glands in armpit			
Symptom: swollen glands in neck			
PSYCHIATRY:PSYCHIATRIC			
Symptom: no known problems			
Symptom: anxiety			
Symptom: depression			
Symptom: suicidal thoughts			
Symptom: mood swings			
Symptom: insomnia			
ALLERGY/IMMUNOLOGY: ALLERGIC			
Symptom: no know allergies			
Symptom: food allergy			
Symptom: dusty allergy			
Symptom: pollen allergy			
Symptom: hay fever			

PATIENT NAME:_____ **DOB:** _____ **DATE:** _____

PAIN QUESTIONNAIRE

NAME	SEX	AGE	HAND DOMINANCE	TODAY'S DATE
	MALE / FEMALE		RIGHT OR LEFT	/ /

HISTORY OF PRESENT ILLNESS:

1. APPROXIMATELY WHAT DATE DID YOUR PRESENT PAIN START? _____
2. WHAT EVENT CAUSED THE PAIN (ACCIDENT, SURGERY, UNKNOWN) _____
   WAS YOUR INJURY ☐ WORK RELATED ☐ MVA ☐ OTHER (SPECIFY) _____
   DESCRIBE WHAT HAPPENED _____
   _____
3. HAVE YOU HAD ANY OF THESE TEST? PLEASE LIST PLACE AND DATE OF TEST

   EMG ☐ YES ☐ NO _____ MYELOGRAM ☐ YES ☐ NO _____
   CT SCAN ☐ YES ☐ NO _____ BONE SCAN ☐ YES ☐ NO _____
   MRI ☐ YES ☐ NO _____ DISCOGRAM ☐ YES ☐ NO _____

4. HAVE YOU HAD ANY INJECTIONS SUCH AS EPIDURAL, TRIGGER POINT, OR FACET JOINT? **(CIRCLE)**
5. PREVIOUS PHYSICAL THERAPY? ☐ YES ☐ NO (WHERE/WHEN) _____

PAST MEDICAL HISTORY:

1. GENERAL MEDICAL PROBLEMS:

   ☐Stomach Problems, ulcer etc. ☐Diabetes ☐Arthritis ☐Gout
   ☐Sexual Difficulties ☐Bowel or Bladder Problems ☐Cancer ☐Heart Disease
   ☐Epilepsy ☐Depression ☐Thyroid Problems ☐High Blood Pressure
   ☐Depression ☐Trouble Sleeping ☐ TB Other: _____

2. ANY RECENT OR PREVIOUS HOSPITAL ADMISSIONS?
   DESCRIBE: _____
3. PRIOR SURGERIES (Unrelated to present problem) TYPE/DATE: _____
4. PLEASE LIST ALL CURRENT MEDICATIONS (Over the counter & prescribed):

   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

FAMILY/SOCIAL HISTORY:

1. HISTORY OF UNUSUAL OR EARLY ONSET OF DISEASE IN FAMILY MEMBERS? _____

   MOTHER: ☐Alive ☐ Deceased Age: ____ Medical Problems: _____
   FATHER: ☐Alive ☐ Deceased Age: ____ Medical Problems: _____
   SIBLINGS ☐Alive ☐ Deceased Age: ____ Medical Problems: _____

2. MARITAL STATUS: ☐ Married ☐ Divorced ☐ Separated ☐Single Number of Children: ____ Children At Home: _____
3. ***ALLERGIES TO MEDICATIONS***:

   Name of Medication: _____ Describe Reaction: _____
4. DO YOU SMOKE? ☐ Yes ☐ No How much? _____ Number of Years you have smoked? _____
5. DO YOU DRINK ALCOHOLIC BEVERAGES? ☐ Yes ☐ No How Much? ☐ Social Drinker Only ☐ _____
6. DO YOU USE STREET DRUGS, MARIJUANA, COCAINE, OTHER: _____
7. MEDICAL EQUIPMENT: ☐Wheel Chair ☐ Power Wheel Chair ☐ Walker ☐Cane ☐Commode

EMPLOYMENT HISTORY:

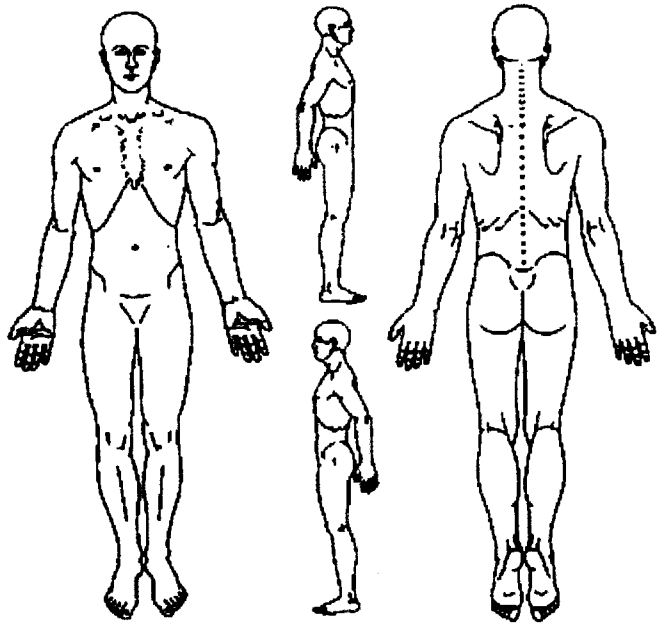
1. ARE YOU EMPLOYED AT PRESENT? ☐ Yes ☐ No ARE YOU CURRENTLY WORKING? ☐ Yes ☐ No
2. IF YOU ARE NOT WORKING, WHEN DID YOU LAST WORK? _____
3. IF YOU ARE NOT WORKING WHICH APPLIES TO YOU?
   ☐ Off by Medical Advice ☐ Quit ☐ Fired ☐ Retired ☐ Position Terminated ☐ Other _____
4. DO YOU HAVE WORK RESTRICTIONS? ☐ Yes ☐ No List: _____

PLEASE FLIP OVER AND COMPLETE OTHER SIDE. 6/1/12

Patient Name: _____ Date: _____

Where is your pain now?

Mark the areas on your body where you feel the described sensation.



Use the appropriate symbol.

ACHE/PAIN	+ + + + + + + + + +
NUMBNESS	0 0 0 0 0 0 0 0 0 0
PINS&NEEDLES	= = = = = = = = = =
BURNING	● ● ● ● ● ● ● ● ● ●
STABBING	/ / / / / / / / / /

Pain Scale

Please **CIRCLE #** on the graph your current pain level.

0= NO PAIN AND 10= WORST PAIN

NECK/BACK PAIN

0 1 2 3 4 5 6 7 8 10

ARM/LEG

0 1 2 3 4 5 6 7 8 10

PAIN PATTERN:

1. DESCRIBE THE DEGREE OF PAIN YOU EXPERIENCE USING ONE OF THE FOLLOWING PHRASES
   ☐BARELY NOTICEABLE ☐MILD ☐MODERATE ☐SEVERE ☐VERY SEVERE ☐UNBEARABLE ☐NO PAIN
2. IS YOUR PAIN: ☐ Constant ☐ Intermittent ☐Occasional?
3. HOW MANY WEEKS, MONTHS, OR YEARS HAVE YOU BEEN DISABLED BY PAIN? _____
4. WHAT ACTIVITIES MAKE THE PAIN WORSE?
   ☐During exercise ☐ after exercise ☐ Sitting ☐ Standing ☐Walking ☐ Bending forward ☐bending backward ☐Coughing ☐Sneezing
   ☐Other: _____
5. WHAT REDUCES YOUR PAIN?
   ☐ Lying down ☐Sitting ☐Standing ☐Walking ☐Manipulation ☐ Physical Therapy ☐Pain Pills ☐ Muscle Relaxants ☐Aspirin
   ☐Other: _____
6. UNUSUAL SYMPTOMS RELATED TO YOUR PAIN (i.e. Nausea, Dizziness, Fatigue, Headaches, etc…)
7. HAS THE PAIN AFFECTED YOUR ABILITY TO WORK? If yes, how _____

Please list additional information which would be helpful in understanding your pain problem.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: _____ (Doctor's Name)

_____ (Doctor's Address)

_____ (Doctor's Phone)

To Release To: **PARAGON PAIN & REHABILITATION, LLP**
Norberto Vargas, M.D. & JP Benavides, D.O. & Melanie Albert, NP & Tim LaVoy, PA
PO BOX 1200 COLLEYVILLE, TX 76034
Phone: (972) 203-3600 Fax: (972) 203-3601/info@paragon-ppr.com

The following information from the medical record of:

Patient Name: _____ Date of Birth: _____
Home Address: _____

Date (s) of Treatment State All or list Dates:_____Social Security No. _____

Information to be released:	____ All Records in Chart	____ EMG/NCV Reports	____ Diagnostic Reports
___ Progress Notes	____ History & Physical	____ Operative/Procedure Notes	
___ Laboratory Reports	____ Consultation Reports	____ Pathology Reports	____ Itemized Bill
___ Other (Specify)_____			

The information specified above is to be released for the following purpose:

____ Treatment/Consultation ____ Patient Request ____ Billing or Claims ____ Attorney ____ Other:_____

Drug and/or Alcohol Abuse, and/or HIV/AIDS Records Release
I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and /or other sensitive information, I agree to its release. I understand that if my medical or billing records contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility privacy officer at the above facility. Authorization valid until revoked in writing.

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative:
I understand that my treatment cannot be conditioned on whether I sign this authorization form. I authorize to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

_____ _____
Signature of Patient or Legal Representative Date

Authority to sign if not Patient: _____

Paragon Pain & Rehabilitation, LLP
Physical Medicine and Rehabilitation/Sports Medicine/Addiction Medicine
Norberto Vargas, M.D. PA John Paul Benavides, DO
P.O. BOX 1200 COLLEYVILLE, TX 76034 (972) 203—3600 Fax (972) 203-3601
Web Site www.paragon-ppr.com

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION
"WARNING CONFIDENTIAL"

X_____ _____
Name of Patient (print) **Patient's Date of Birth**

X_____ _____
Signature of Patient **Date of Signature**

Request for Confidential Communication of Your Protected Health Information

Representative's Relationship to Patient: _____

Specific Request: _____

X_____ _____
Printed Name of Patient's Representative **Representative Date of Birth**

X_____ _____
Signature of Representative **Date of Signature**

Please circle the following:

1. May we leave messages concerning your appointments with whom ever regularly answers your calls?	**Yes**	**No**	**N/A**
2. May we leave messages on a voice mail?	**Yes**	**No**	**N/A**
3. May we discuss you appointment/treatment with your spouse?	**Yes**	**No**	**N/A**
4. If you are over the age of 18, still living at home, may we discuss your appointment/treatment with your parent(s) or guardian?	**Yes**	**No**	**N/A**
5. If you are over the age of 18, may we discuss your appointment and/or treatment with your children?	**Yes**	**No**	**N/A**
6. Email communication with practice at info@paragon-ppr.com	**Yes**	**No**	**N/A**
7. I allow you to email me about appointments, billing, clinic treatment	**Yes**	**No**	**N/A**

[redacted] in writing if you wish to change the manner in which this office communicates to you.

PARAGON PAIN & REHABILITATION, LLP

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information;
- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- The right to receive a printed copy of this notice.

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:
HIPAA Privacy Officer
Paragon Pain & Rehabilitation, LLP P.O. BOX 1200 COLLEYVILLE, TX 76034

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.