ROBERT D. MOCK, M.D.

Family Practice

Notice Regarding Preventive Care

With the passage and enactment of the Affordable Care Act (aka "Obamacare"), many (but not all) insurance plans are now required to offer their members coverage of certain preventive care services with no patient copay, deductible, or other cost-sharing, as long as these services are provided by in-network health professionals.

Preventive care services include:

- Items recommended by the U.S. Preventive Services Task Force (USPSTF) with an A or B evidence rating.
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the CDC.
- Items for women supported by the Health Resources and Services Administration per the August 1, 2011 guidance.

Preventive care services do NOT include:

- Evaluation & treatment of any existing medical problem(s) or condition(s), for example routine visits for refills of long-term medications or evaluation or treatment of pain or illness.
- Physical examination of anything other than that recommended by the guidelines mentioned above.

An annual preventive care visit is not a physical; it is just a review of the preventive care services you qualify for based on your age, gender, and other health risk factors and then the provision of or referral for those particular services.

If you are coming in to see a doctor for any particular reason(s) (e.g. refills for hypertension treatment), it is not a preventive care examination. **Preventive care visits cannot take the place of an office visit you would normally need for routine medical management or to address a medical concern.**

Please note that if your preventive care visit results in the diagnosis of any medical condition(s) which require(s) treatment, a separate office visit charge will have to be billed in addition to the preventive exam charge. If you have any cost sharing for office visits (e.g., copay or deductible), you will be financially responsible for this.

However, if your preventive visit does not reveal any specific medical conditions that would necessitate further medical evaluation or treatment and your insurance covers preventive visits with no patient cost-sharing, we would anticipate that you have no out-of-pocket costs.

Also note that some insurance policies may limit how often they cover a preventive care visit (for example, one every twelve months or one every calendar year). You may need to review your records and inquire from other physicians (especially other ob-gyn, family practice, or internal medicine doctors) whether you have had a recent preventive visit elsewhere. Please be sure to not exceed the frequency limitations of your plan as any amount denied by your insurance is your financial responsibility.

I, _____ (Print Your Name), the undersigned, have read and understand this notice and agree to notify both the office staff and Dr. Mock before receiving services if I want to a particular appointment to be conducted as an annual preventive visit.

For my appointment today, I wish to:

(CIRCLE **ONE** OF THE FOLLOWING)

ADDRESS MY MEDICAL CONCERNS & RECEIVE APPROPRIATE EVALUATION/TREATMENT/MEDICATION AS NEEDED (i.e., normal office visit)

OR

RECEIVE A PREVENTIVE EXAM RELATED TO MY AGE, GENDER, & GENERAL RISKS AS OUTLINED ABOVE BUT NOT ADDRESS INDIVIDUAL MEDICAL CONCERNS OR RECEIVE ANY EVALUATION/TREATMENT/MEDICATION FOR PARTICULAR COMPLAINTS OR CHRONIC ILLNESSES (i.e., annual preventive visit)

_____ _____

Patient Signature Date

ROBERT D. MOCK, M.D.

Family Practice

PATIENT & INSURANCE INFORMATION

LAST NAME		**FIRST NAME**	**MI**
MAILING ADDRESS			
CITY		**STATE**	**ZIP**
HOME #	**WORK#**	**CELL #**	
DATE OF BIRTH		**SEX**	
SSN		**MARITAL STATUS**	
EMAIL			

INSURANCE INFORMATION (ONLY NEEDED IF INSURANCE CARD IS NOT AVAILABLE)

INSURANCE COMPANY		
CLAIMS ADDRESS		
CITY	**STATE**	**ZIP**
PHONE NO.		
ID NO.		
GROUP NO.	**COPAY**	

PRIMARY INSURED'S INFORMATION (IF OTHER THAN SELF)

NAME		
BIRTHDATE	**RELATIONSHIP TO PATIENT**	
SSN		
ADDRESS		
CITY	**STATE**	**ZIP**
HM PHONE	**WK PHONE**	
EMPLOYER		
ADDRESS		
CITY	**STATE**	**ZIP**

1120 Medical Plaza Drive Ste 380 • The Woodlands, Texas 77380-3243
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NPI: 1932196896

ROBERT D. MOCK, M.D.

Family Practice

FINANCIAL POLICY

We require that all patients read and sign our Financial Policy prior to seeing the doctor. Payment for service is required at the time services are rendered.

We may accept assignment of insurance benefits. However, you must understand and agree to the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding benefits, deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Any services rendered that are not covered benefits are your responsibility. It is YOUR responsibility to determine your covered benefits BEFORE accepting treatment.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. I understand that employees of Robert Mock, M.D. are NOT representatives of my insurance company and any estimate I receive from them is not a guarantee of payment from my insurance company.
5. There will be a fee charged for returned checks.
6. Balances older than 60 days may be subject to collection placement and fees.
7. I authorize payment from my insurance carrier be made directly to Robert D Mock, MD.
8. I authorize this office to release necessary medical information about me to my insurance carrier.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account.

Thank you for choosing Robert D. Mock, M.D. as your family healthcare provider. We appreciate your trust in us and the opportunity to serve you.

_____

Signature of Patient or Legal Representative **Date**

Name of Legal Representative & Relationship to Patient (if applicable): _____

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MEDICAL HISTORY (Page 1 of 2)

Name _____ **Date of Birth** _____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY.

Please list <u>all medications you are currently taking</u>, whether prescribed by Dr. Mock or another provider. Include name of medication, strength of medication, how you are supposed to take it, and who prescribes it.

Please list all adult immunizations you know you have had, such as pneumonia, shingles (Zostavax), HPV, tetanus, hepatitis A, hepatitis B, influenza, etc., and approximately when you had them.

Please list your known, chronic medical conditions or write "none known".

Which (if any) specialists are you currently (within the last 2 years) seeing? For which medical conditions?

Besides your chronic conditions, do you have any new or additional medical problems Dr. Mock may need to address?

List all allergies and side effects that you have had to medication or food and describe what happened.

List all previous surgeries you can recall having, including the type of surgery and the month/year of surgery to the best of your recollection.

List all (if any) hospitalizations you have had in the last 2 years, including the hospital name, the month/year of hospitalization, and the reason for hospitalization.

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MEDICAL HISTORY (Page 2 of 2)

Name _____ **Date of Birth** _____

FAMILY HISTORY

How many brothers do you have? Are they all generally healthy or not? _____
How many sisters do you have? Are they all generally healthy or not? _____
How many sons do you have? Are they all generally healthy or not? _____
How many daughters do you have? Are they all generally healthy or not? _____

Family		DOB or Age	Medical Conditions
Mother	Alive? Deceased?		
Father	Alive? Deceased?		
Siblings	Alive? Deceased?		
Paternal Grandfather	Alive? Deceased?		
Paternal Grandmother	Alive? Deceased?		
Maternal Grandfather	Alive? Deceased?		
Maternal Grandmother	Alive? Deceased?		
Children	Alive? Deceased?		
Other:	Alive? Deceased?		

SOCIAL HISTORY

Are you a _____ Current Smoker _____ Former Smoker _____ Never Smoker?

Do you currently chew tobacco? Yes _____ No _____ ?

Are you sexually active? Yes _____ No _____ ?

Do you drink alcohol? Daily _____ Socially _____ Rarely _____ Never _____

OTHER INFO

	Year Last Performed	Doctor Who Ordered/Performed
Colonoscopy		
EKG		
Bone Density Scan		
Mammogram		
Pap Smear		
Prostate Cancer Screening (PSA)		
Chest X-Ray		
Lab Tests Done, What Type		
Physical		

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Robert D Mock MD

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Shenandoah TX 773803242
Ph: 281-363-3311 Fax:281-363-3158

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: **Date:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Total Score:

Interpretation

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately severe depression
- ☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

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Patient Name: _____ Date of Birth: _____

Today's Date: _____

Due to our transition from paper to electronic medical records, federal government regulations arising from the HITECH Act of the 2009 stimulus package now require us to attempt to collect additional bits of demographic information. This is collected once and of no interest to us for your care. We apologize for any inconvenience, confusion, or personal offense this may cause you. Thank you for your understanding.

Please mark one of the following for each demographic category:

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Other……*Specify* _____

RACE

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Hispanic
- ☐ Other Pacific Islander
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Unreported / Do Not Wish to Report

ETHNICITY

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Do Not Wish to Report

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ **SSN**: _____

MAILING ADDRESS: _____

_____

HOME PH#: _____ **CELL PH#:** _____

WORK PH#: _____ **EMAIL:** _____

PURPOSE OF CONSENT - PLEASE READ CAREFULLY.

ACKNOWLEDGEMENT AND CONSENT: By signing this form, you are acknowledging receipt of a written copy of our Notice of Privacy Practices. More importantly, you are consenting to our use and disclosure of your protected health information as it is described in the Notice of Privacy Practices. We reserve the right to change our privacy practices, as described in the Notice of Privacy Practices. Your consent applies to the Notice of Privacy Practices currently in effect, as well as any revised Notice of Privacy Practices that may replace the current one. Should there be any changes to the current Notice of Privacy Practices, you will be provided a written copy of the new Notice.

RIGHT TO REVOKE: You have the right to revoke this consent at any time. For your revocation to be valid, you notify our office of your revocation in writing. Your revocation will have no bearing on any use or disclosure of your protected health information made prior to our receipt of your revocation. Please understand that if you chose to withhold or revoke your consent to our privacy practices, as outlined in the Notice of Privacy Practices, we must decline to treat or continue treating you.

I, _____ , have had the opportunity to fully read and understand the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information, in the manner described in your Notice of Privacy Practices. Further, I give consent for any health care provider or diagnostic facility in possession of any type of my protected healthcare information to release the same, including mental health records, to Robert Mock, M.D., for my ongoing treatment and care. This consent is valid until a written revocation is provided to Dr. Mock's office.

_____

Signature of Patient or Legal Representative **Date**

Name of Legal Representative & Relationship to Patient (if applicable): _____

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SPECIFIC AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Notice of Privacy Practices describes the manner in which our office will use and disclose your protected health information, in accordance with federal law. These privacy laws provide certain protocols for the release of protected health information to personal representatives, relatives, friends, and other individuals involved with your medical care. Our office will maintain compliance with these laws, as stated in the Notice of Privacy Practices, at all times. However, to simplify this process, we ask that you designate those individuals who may act as your personal representative, or are in some way involved in your medical care. You may revoke any or all of these authorizations, at any time, by providing our office a written revocation. This revocation will not affect any disclosures of your protected health information made prior to our receipt of your written revocation.

NAME: _____ PH#(S): _____

RELATIONSHIP:_____ PRIMARY EMERGENCY CONTACT? Y N

NAME: _____ PH#(S): _____

RELATIONSHIP:_____ PRIMARY EMERGENCY CONTACT? Y N

NAME: _____ PH#(S): _____

RELATIONSHIP:_____ PRIMARY EMERGENCY CONTACT? Y N

NAME: _____ PH#(S): _____

RELATIONSHIP:_____ PRIMARY EMERGENCY CONTACT? Y N

NAME: _____ PH#(S): _____

RELATIONSHIP:_____ PRIMARY EMERGENCY CONTACT? Y N

By signing below, I am giving authorization for full disclosure of my protected health information to the parties named above. Further, I authorize members of Dr. Mock's staff to add other names to this list in the future, when and if I have requested that they do so. If I choose to make such a request over the telephone, I authorize Dr. Mock's staff to use my social security number or my date of birth for identification purposes. I understand that the above list is not exhaustive, and that other disclosures of my protected health information will occur, in accordance with the Notice of Privacy Practices.

_____

Signature of Patient or Legal Representative **Date**

Name of Patient: _____ **Date of Birth:** _____

Name of Legal Representative & Relationship to Patient (if applicable): _____

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SUMMARY OF THE NOTICE OF PRIVACY PRACTICES

This summary is intended to assist you in understanding the attached Notice of Privacy Practices.

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, uses and disclosures of your health information, and our common practices relating to patient health information.

Uses and Disclosures of Health Information- We will use and disclose your health information in order to treat you, and to assist other health care providers in treating you. We will also use and disclose your health information to obtain payment for our services, when obtaining prior authorization for future services, or to facilitate other health care providers in obtaining payment for services or authorization for services. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, and student training.

Uses and Disclosures Based on Your Authorization- Except as stated in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization- In the following circumstances, we may disclose your health information without your written authorization:

- To obtain payment for our services provided to you or on your behalf.
- To assist other health care providers in treating you, and in obtaining payment for services provided to you or on your behalf.
- For certain limited research purposes.
- For purposes of public health and safety.
- To Government agencies for purposes of their audits, investigations, and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or others incidents.
- To law enforcement authorities to assist in the protection of public safety and or the apprehension of criminal offenders.
- As required by law for court orders, warrants of search and seizure, subpoenas, etc.

Patient Rights- As our patient, you have the following rights:

- Access to your health information, or a copy of the same, in accordance with relevant government statutes and legalities.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our privacy practices.

Please note, as a patient, you are guaranteed the right to make certain requests, but our compliance with your request is at the discretion of the physician or the office manager. However, we will generally facilitate reasonable requests pertaining to your health information.

If you have a question, concern, or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for information on the person or persons you may contact.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO OUR OFFICE.

Our Legal Duty

We are required by the applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we revise or replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that the proposed changes are permitted under the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information created before we made the changes. You may request a copy of our notice, or any subsequent revised notice, at any time. For more information about our privacy practices, or for additional copies of this notice, please contact our office using the information provided at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information to facilitate treatment, payment, and health care operations. The following are examples of the types of uses and disclosures of your protected health information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment- We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physical therapy facility or a home health care agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you. In addition, we may disclose your protected health information to another physician or health care provider who, at the request of your physician, becomes involved in your care. For example, a laboratory or radiology facility may assist your physician in diagnosing and treating you.

Payment- Your protected health information will be used and disclosed, as necessary, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you. These activities often include making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities necessary to approve services.

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Health Care Operations- We may use or disclose your protected health information, as needed, in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, the training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail. We will share your protected health information with third party "business associates" that perform various activities for our practice, such as billing or transcribing. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a confidentiality agreement that protects the privacy of your protected health information. We may use or disclose your protected health information, as needed, to provide you with information about treatment alternatives or other health-related benefits or services that may be of interest to you. We may use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization- Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law, as described below. You may give us written authorization to use your protected health information or to disclose it for any purpose. If you give our office an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care- Unless you object, we may disclose to a family member, relative, close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may choose to disclose your health information, if we determine that it is in your best interest, based on our professional judgment. We may use or disclose protected health information to notify, or assist in notifying, a family member, personal representative, or any other person involved in your health care your location, general condition, or death.

Marketing- We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist our office with these activities. Unless the information is provided to you by a general newsletter or in person, you may opt out of receiving such information.

Research, Death, and Organ Donation- We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety- We may disclose your protected healthcare information to the extent necessary to avert a serious and imminent threat to your health or safety, or health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system, government programs or contractors, and to public health authorities.

Health Oversight- We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental agency authorized to receive such information. In this case, disclosure will be made consistent with the requirements of the applicable federal and state laws.

Food and Drug Administration- We may disclose your protected health information, as required, to an individual or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance.

Criminal Activity- Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law- We may use or disclose your protected health information when we are required to do so by law. For example we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings- We may use or disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement- We may disclose limited information to a law enforcement official, concerning the protected health information of a suspect, fugitive, material witness, crime victim, or missing person. Under certain circumstances, we may disclose the protected health information of an inmate, or other person in lawful custody, to a law enforcement official or correctional institution. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

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Patient Rights

Access-You have the right to look at your protected health information, or get copies of the same, with limited exceptions. You must provide our office with your written request to obtain access to your protected health information. If you request copies of your protected health information, you may be required to pay a fee for this service. The purpose of this fee is to compensate our office for the time and resources required to furnish you with the requested information. We reserve the right to determine whether or not a fee will be charged and the amount of the fee, on a case by case basis.

Accounting of Disclosures- You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations, or certain other activities, after April 14, 2003. After April 14, 2009, the accounting will be provided only for the past six years. We will provide you with the date we made the disclosure, the name of the entity to whom we disclosed your information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these requests.

Restriction Requests- You have the right to request that we place additional restrictions on the use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in cases of emergency. Any agreement we make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on behalf of our office. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication- You have the right to request that we communicate with you in confidence about your protected health information by an alternative means or at an alternative location. You must make your request in writing. We will accommodate reasonable requests if it specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment- You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended, or for certain other reasons. If we deny your request, we will provide you with a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information you wanted to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment, to be included in any future disclosures of that information.

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Electronic Notice- If you receive this notice in an electronic format, you are entitled to receive this notice in written form. You may contact our office to obtain your written notice, if you so desire.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact our office using the information provided below. If you believe that we may have violated your privacy rights, or if you disagree with a decision we have made regarding your protected health information, you may address your complaint to our office using the information provided below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: Robert D. Mock MD
Contact Address: 1120 Medical Plaza Drive, Ste. 380
The Woodlands, Texas 77380

Contact Phone: (281) 363-3311
Contact Fax: (281) 363-3158