WELCOME TO OUR OFFICE!

We welcome you to our Clinic. Our goal is to provide the highest quality medical care possible for our patients. This brochure outlines the services provided by the Brown Family Health Center, Inc. Our specially trained staff is comprised of Dr. Ajose, MD, Carolyn Patton, RN FNP-C, Heather Alex, LVN and NeMeena Flemon, Billing Coordinator. Our staff operates as a team, and we take great pride in each member's training.

SERVICES PROVIDED:

Primary Care
Immunizations
Well-Child Checks
Minor Surgical Procedures
Women's Health
School/Sports Physicals

SERVICES REFERRED:

Specialty care, such as cardiology, dermatology, nephrology, to name a few
X-rays
Major Surgical Procedures
Any other service that provider feels cannot be handled in clinic

ABOUT DOCTOR AJOSE:

Dr. Ajose is a native of Nigeria. Dr. Ajose obtained his Doctor of Medicine degree from University of Lago in Lagos. He completed a hospital residency at Bronx Lebanon Hospital, in Bronx, NY. Dr. Ajose is certified by the American Board of Internal.

Dr. Ajose and his family live in Nacogdoches, TX.

ABOUT OUR NURSE PRACTITIONER:

A Nurse Practitioner is a registered nurse who has advanced education and clinical training in a health care specialty. Most Nurse Practitioners have national certification in their area of expertise. Nurse Practitioners serve as primary health care providers for children and adults during health and illness. Their goal is to help people of all ages stay as healthy as possible. They do this by teaching people and treating their acute illnesses (such as infections) and chronic disease (such as diabetes).

Nurse Practitioner can:

- Physical examination, treatment & procedures
- Order and interpret laboratory and diagnostic studies
- Family planning service
- Healthcare during pregnancy
- Well/sick care for all ages
- Health risk evaluation
- Psychological counseling
- Coordination of health care services
- Health education

Carolyn Patton, RN FNP-C is a native of Texas. She completed her undergraduate work at Stephen F. Austin State University. She obtained her Master's Degree in Nursing from Texas Tech University. She is certified as a family nurse practitioner through the American Academy of Nurse Practitioners (AANP). She is a member of the AANP, Texas Nurse Practitioners, Association of Nurses in AIDS Care and Sigma Theta Tau nursing honor society.

Mrs. Patton and her family lives here in Nacogdoches, TX.

APPOINTMENTS:

Patients are seen by appointment. Otherwise, patients coming to the clinic are "worked-in" to the schedule as time permits. Please try to arrive a few minutes early so that the business office can have you ready to see the doctor on time. Your first visit will take longer than most other visits. You will be asked to complete a medical history and give us other important information.

There are certain forms that must be completed before the provider can see you as a patient. The business office will provide you with all the necessary forms for you to read and sign.

You will need to provide the business office with you Insurance card, Medicare card, and/or Medicaid card.

If you have any questions about any of the forms, just ask the receptionist and she will have someone help you fill them out.

You have rights and responsibilities as a patient. Please read the sheet titled: PATIENT RIGHTS & RESPONSIBILITIES that is included with the packet of information you were given by the receptionist.

If you are unable to keep a scheduled appointment, please call our office at least twenty-four hours before your scheduled appointment time.

FINANCIAL ARRANGEMENTS:
Payment for the services you receive is expected before you leave today. If you have insurance, you are expected to pay your co-pay amount today.

If your insurance has a deductible that you have not met, your insurance company will let you know, AND you will receive a bill from our office. It can take up to six weeks to get all the information to the right people, so it may take that long for you to get the bill from us.

Patients that do not have any insurance, Medicare or Medicaid coverage are considered "private pay" patients. These patients are expected to pay the full amount of the charges for the day before leaving the office, unless the Doctor has advised the business office of any other arrangements.

Our fees are based on the time, skill, knowledge and complexity of your treatment. We make every effort to keep our fees in line with what other providers in the area are currently charging.

INSURANCE:
If you have insurance, we will help you file for the coverage you have available, however, it is YOUR responsibility to pay any balance on your account that is left after the insurance pays their part.

Please keep in mind that medical care is provided to you, our patient, and not to an insurance company. Your insurance benefits are an agreement between you and the insurance company. We are not involved in any way with your insurance policy.

It is important that you read your policy carefully to help you understand the benefits your policy provides to you. The non-covered services, co-payments and deductibles are due the day you receive the service at our clinic.

Some insurance companies pay a fixed amount for certain procedures, which means you are responsible for anything the insurance does not pay. If your plan is limited, then your coverage amounts are limited. We have no control over what your insurance company pays for your care. Please remember that no insurance company attempts to cover all costs. Our office wants you to receive the maximum coverage that your particular policy allows.

URGENT CARE NEEDS:
There are times when you need to see the provider as soon as possible. If your situation is determined to be urgent, you will be advised to go to the Emergency Room. If your medical problem can be handled in our office, every effort will be made to "work you into" the day's appointment schedule.

Please understand that you may be asked to wait one or two days, depending on the office schedule and the nature of your illness.

If you prefer to speak with the nurse, you are welcome to leave a message for the nurse to return your call. Messages received by 3:00 p.m. will be returned no later than 4:00 p.m. Phone messages received after 4:00 p.m. may be returned the following clinic day, depending on the patient schedule.

PATIENT PORTAL INFORMATION SHEET AND SIGNED CONSENT

How Secure Patient Portal Works:

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be ready by someone who knows the right password or pass-phrase to log in to the portal site. It is your explicit responsibility to maintain the security of your login and password.

How to participate in our Patient Portal:

Once this form is agreed to and signed, we will send you an email notification that tells you how to register for the first time. This notification will give you the URL (internet address) of the web site where you can log in. By clicking on the URL you will activate your Internet browser, which will open the web site. You will then be able to login using the user name and password provided. Next you will be able to look in your "inbox" and see any new or old messages or view others parts of your electronic record. Because the connection channel between your computer and the web site uses "secure sockets layer" (SSL) technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks"

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are correct. **We need you to make sure we have your correct email address and you must inform us if it ever changes.** You also need to keep track of who has access to your email account; so that only you, or someone you authorized, can see the messages you receive from us. If you pick up secure messages from a Website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the Patient Portal and change it. It is our intent to offer this as a free service, but we reserve the right to change this policy. We will provide adequate notice of any changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never see or give away any private information, including email addresses, without your written consent.

Conditions of Participating in the Patient Portal:

Access to this secure Patient Portal is an optional service and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service we will notify you as promptly as we reasonably can. You agree not to hold The Brown Family Health Center/Health Horizons of East Texas, or any of its staff liable for network infractions beyond its control.

If you agree to abide by the conditions set forth on this letter and wish to have a Patient Portal account created for you, please sign and date.

_____	_____	_____
Signature	Printed Name	Date

Patient Registration Form

First Name _____ **Middle** _____ **Last** _____

Address _____

City _____ **State** _____ **Zip** _____

Date of Birth _____ **Age** _____ **Sex** _____ **SS#** _____

Phone # (_____) _____-_____ **Cell #** (_____) _____-_____

Email _____

Emergency Contact Name/# _____

Preferred Method of contact: Circle One: Email Letter Telephone

Race: White/Black/Hispanic/ American Indian/Alaska Native/ Asian/Pacific Islander
Ethnicity (Circle One): Hispanic / Non-Hispanic
Veteran: (Circle One): Yes No

Single _____ Married _____ Partnered _____ Widowed _____ Divorced _____

Preferred Language _____

Employed by _____
Work # _____ Ext _____

Name of Spouse/Partner _____
Date of birth _____ SS# _____
Employed by _____
Work # _____ Cell # _____

Medicare or Medicaid # _____
OR
Primary Insurance _____
Insured's Name _____
Insured's Date of Birth _____ SS# _____
Policy# _____ Group # _____

Secondary Insurance _____
Insured's Name _____
Insured's Date of Birth _____ SS# _____
Policy# _____ Group # _____

Preferred Pharmacy _____

Assignment of Benefits:
I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other plan to Brown Family Health, Health Horizons of East Texas, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to request a review of claim.

Signed: _____ **Date:** _____

BROWN FAMILY HEALTH CENTER
HEALTH HORIZONS OF EAST TEXAS, INC.

NEW ADULT PATIENT HEALTH HISTORY

Name:_____ Date:_____
Address:_____ DOB:_____
Age:_____ Sex:_____ Marital Status:_____
Education Level:_____Did not Complete High School _____High School Diploma/GED _____College
Employment:_____Unemployed _____Employed Fulltime/Part-time _____Disabled _____Retired

PAST MEDICAL HISTORY: *Please check any of the following conditions/problems/diseases that you either have or have been diagnosed with in the past:*

	Abuse (Physical/Mental/Sexual/Verbal)		Blood Clots		Kidney/Bladder Problems
	Abnormal Pap		Cancer/Tumor		Lung Disease
	Alcoholism/Drugs		Cholesterol (high)		Osteoporosis
	Anemia		Diabetes		Serious Accident/Injury
	Anxiety/Nerves		Gout		Sexual Disease
	Arthritis		Headaches/Migraines		Stroke
	Asthma/Allergies		Heart Disease		Thyroid Disease
	Bleeding Disorders		Hepatitis (Any)		Tuberculosis
	Other		High Blood Pressure		Ulcers/Stomach disease

CURRENT MEDICATIONS: *List all medications that you take routinely or that have been prescribed for you by a health care provider (include vitamins, over-the-counter medications, eye drops, herbal medications)*

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

Allergies:		None		PCN		Sulfa		Codeine		Ace Inhibitors		Insects		Pollen		Latex		Foods		Contrast

FAMILY HISTORY:

Blood Relative	Age if Living	Age at Death	Major Illness and/or Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Brothers			
Sisters			

PAST SURGICAL HISTORY: *List the year you had any of the following:*

	Appendectomy		Gallbladder		Hernia		Tonsillectomy
	C-Section		Heart		Hysterectomy		Tubal/Vasectomy
Others:							

HOSPITALIZATIONS:

Date: (start with most recent)	Reason:	Where:

HABITS:	Do you use (or have you used) any of the following:												
Tobacco:		Never		Now		Quit: Year	Type used:		Cigarettes		Cigars		Smokeless
Alcohol:		Never		Now		Quit: Year	Type used:		Beer		Wine		Liquor
Drug Usage:		Never		Now		Quit: Year	Type used:		Marijuana		Cocaine		Other:
Caffeine:				Coffee		Tea			Soda				

Exercise:		None		# of times per week	Doing what	

NUTRITIONAL ASSESSMENT

Do you follow a specific diet or have any dietary restrictions?		**No**		**Yes**

HEALTH CARE MAINTENANCE

Last Cholesterol Screen?	Year:		Value:					
Pneumonia Shot?		Never		Year	Tetanus Shot?		Never		Year
Have you been involved in:		Military?		International Travel?				

COPING/STRESS TOLERANCE ASSESSMENT

Describe how you manage stress:		Exercise		Gardening		Hobbies		Read		Sports		TV
Who lives with you?		Alone		Spouse				Children		Parent(s)		Other
Current Stressors		Family		Friends				Job		Marriage		Money
In the past year have you had a major loss or change in your life?								Yes		No		

Values/Beliefs Assessment

Check if you have any of the following documents:		Donor Card
		Living Will
		Durable Power of Attorney for Health Care

Do you have any religious or cultural practices we should be aware of?		Yes		No

Describe:

Patient Signature/Date Completed

Provider Signature/Date Reviewed

BROWN FAMILY HEALTH CENTER

CLINIC FINANCIAL POLICY

CASH PAY PATIENTS

Patients without medical insurance, or have insurance and choose not to utilize their insurance benefits due to policy restrictions or limitations, are required to pay for their medical visits at a discounted cash rate. These policies are outlined as follows:

New Patients are required to pay a new patient exam fee of $84.00. After you are an established patient each returning visit is $56.00 due at time of service.

Established Patients and/or patients returning to the clinic less than 2 years from their last visit are required to pay a discounted rate of $56.00 at each visit. This fee is for services including, but not limited to: physical examination by medical provider.

Any patients returning after 3 years from their last visit are considered a New Patient and should follow the New Patient payment policy above.

Any laboratory services ordered and/or provided during the visit are not part of the visit fee and will incur an additional charge. Lab costs vary according to which tests the provider orders. All fees will be discussed with patient before labs are drawn.

We are happy to accept your check, Credit/Debit Card or Cash as payment.

The below signature acknowledges that I have read the above statement and understand the policy and financial responsibility. Payment will be made at each time of service to Brown Family Health Center, Inc located at 1407 East Main Street, Nacogdoches, TX 75961.

_____ _____

Patient Signature Date

_____

Printed Name

Brown Family Health Center
1407 East Main Street
Nacogdoches, TX 75961

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notices of Privacy Practices, which explains how my medical information will be used and disclosed. I have been given an opportunity to ask questions if I do not understand.

_____ I understand that I am entitled to receive a copy of this document.

Initial

PHARMACY QUERY PERMISSION

By signing below, I give the office of the Brown Family Health Center, Inc. permission to query all medications prescribed to me from the online pharmacy database.

_____

Initial

CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of BROWN FAMILY HEALTH CENTER, INC. and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from BROWN FAMILY HEALTH CENTER, INC. providers, or until I withdraw my consent in writing.

_____

Initial

_____

Signature of Patient or Personal Representative

_____ _____

Printed Name of Patient Date of Birth

_____

Date

BROWN FAMILY HEALTH CLINIC, INC

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.

If you have any questions about this Notice please contact
BROWN FAMILY HEALTH CLINIC, INC
1407 EAST MAIN
NACOGDOCHES, TX 75961
(936) 569-8240

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

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

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health 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 or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. 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 such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

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

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

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

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

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

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

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by [describe how patient may obtain a restriction.]

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our office:

Brown Family Health Clinic, Inc
1407 East Main
Nacogdoches, TX 75961
(936) 569-8240

for further information about the complaint process.

This notice was published and becomes effective on July 1, 2014.