D. Victoria Martin, M.D.
Child, Adolescent and Adult Psychiatry

1221 Abrams Road, Suite 100
Richardson, Texas 75081
972-994-0540
Fax: 972-994-0978
office@victoriamartinmd.com

Dear New Patient,

Hello! We are pleased that you have chosen Dr. Victoria Martin, M.D. to provide a very important part of your health care. Our entire staff sincerely strives to provide you with the most professional, efficient and confidential services possible. We also want you to feel comfortable in our office.

This letter will fill you in on just what to expect on your first visit.

Your first appointment is a complete Psychiatric Evaluation. When you arrive, please sign in on the clipboard by the receptionist window. The receptionist will collect your paperwork and payment. While you relax in our waiting room for a few minutes, we will prepare the paperwork for the doctor's use. Dr. Martin will call you, usually by first name, and invite you to her private office where you will spend about an hour in an interview–type setting. At the end of the session the doctor will render a diagnosis and present a treatment plan.

If the new patient is an adult, it's their choice of whom, if anyone accompanies them. If the new patient is a minor, then a parent, guardian or other adult family member must accompany them.

Important Issues:

[1] Paperwork: Estimated time required to complete: 30 to 60 minutes.

All forms with this cover letter (Dr. Martin's Comprehensive History and Mental Health Assessment Questionnaires packet) are required to be completed **before** your appointment. The doctor needs ALL the requested information in order to make an accurate differential diagnosis.

Also, if your scheduled appointment is (just for example) 11:00 AM, and you come in to the office at 11:00 AM… with incomplete paperwork, you may have to reschedule. Dr. Martin requires one full hour with you one-on-one to complete an accurate evaluation. In the above scenario, there is probably someone scheduled at 12 noon. If it took 30 minutes to complete your paperwork, our schedule would be off by at least 30 minutes. Rescheduling would avoid inconveniencing other scheduled patients for the rest of that day. It is recommended that you arrive in our office 10 – 15 minutes before your scheduled appointment with Dr. Martin if you have the completed paperwork and **45 – 60 minutes early if the paperwork is not complete.**

[2] Office Location: Use our Map and Directions

We want your experience with us to be as pleasant as possible. Getting lost is not pleasant! PLEASE, use the Map and Directions included in this packet. The problem arises from the fact that our street address is on Abrams road. Our building is actually at least one-half block off Abrams. You will enter our parking lot from Tall Oaks Lane. Google, Mapquest or Yahoo will point you roughly to a spot on Abrams near Tall Oaks, which more times than not, causes confusion.

Also, by the way, we are one block inside Richardson from the Dallas border. If you search for 1221 Abrams in Dallas (instead of Richardson), you'll end up miles away!

We really look forward to meeting you in person! If you have any questions, problems, or need help in any way relating to your treatment in this office, please call us.

Our Best Regards!

Dr. Martin's Office Staff

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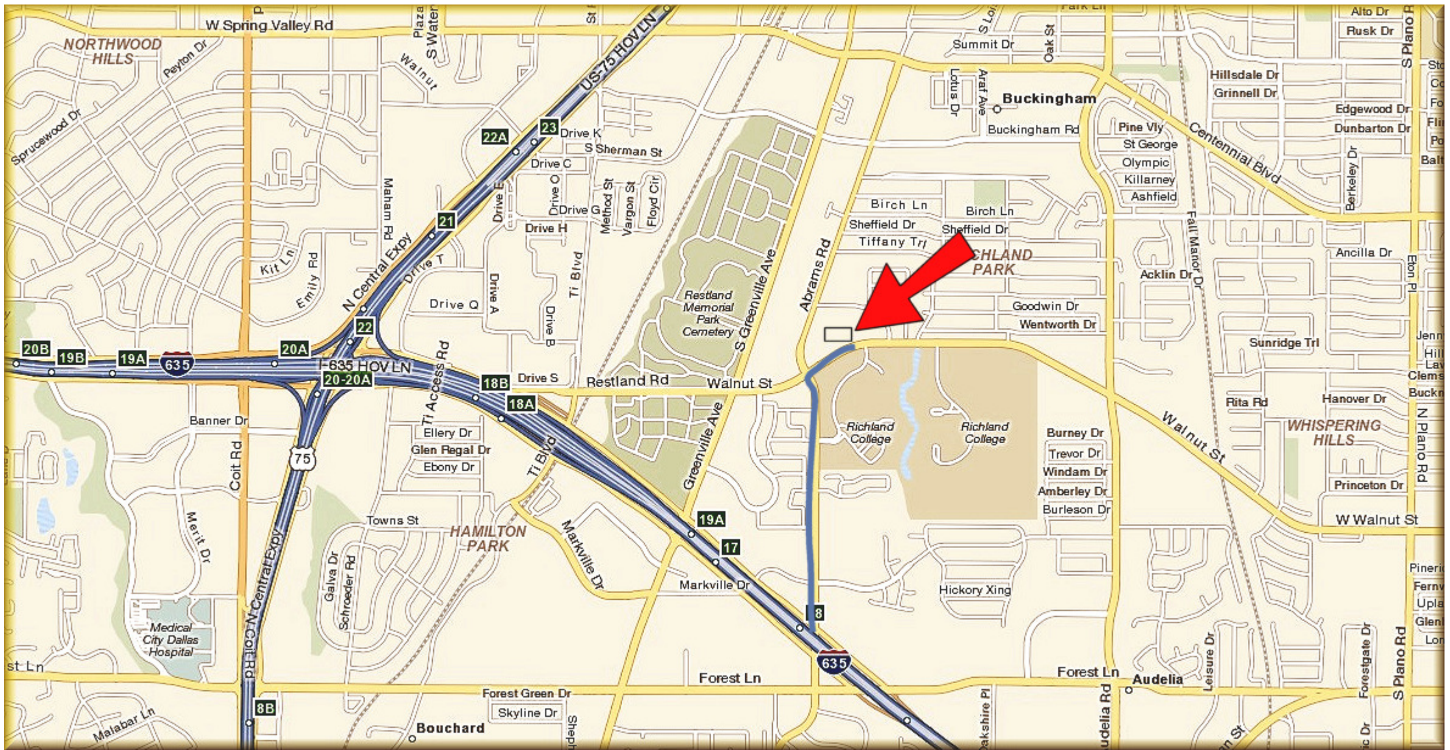
Directions to Dr. Martin's Office



1221 Abrams Road, Suite 100, Walnut Abrams Plaza, **R i c h a r d s o n**, Texas 75081

From the junction US-75 (North Central Expressway) and I-635 (LBJ Freeway):

- ☑ Take I-635 east, (just past Greenville Ave), and take Exit 17 for Abrams Road
- ☑ Turn left (north) on Abrams Road for one mile to the traffic light at Walnut Street
- ☑ Turn right (east) on Walnut Street
- ☑ Take the first available left into the Walnut Abrams Plaza

Our office is in the three-story red brick office building facing Walnut Street and Richland College. We recommend that you park on the south side of the building (the side facing Walnut) and come in through the southeast entrance.

- ☑ Suite 100 is in the center of the east side of the first floor atrium.

Tips-

Walnut Street is the dividing line between Dallas and Richardson. Addresses on the Dallas side of Abrams are five digits long and become four digits long on the Richardson side.

If you use GPS or Google Maps, it's 1221 Abrams in Richardson, NOT Dallas.

- ☑ Feel free to call if you have any problem finding us! **972.994.0540**

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Registration

Today's Date: ______________________________

Patient Name and Address

First Name:				Address:	
Initial:				City:	
Last Name:				State:	
Date of Birth:		Current Age:		Zip code:	

Patient Contact and Personal Info

Primary Phone:		Driver License:		State issued:	
Secondary Phone:		Social Security:			
Email Address:		Gender:	❒ Male ❒ Female		
Employer:		Marital:	❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed		
Employer Phone:		Student Status:	❒ None ❒ Part Time ❒ Full Time		

Emergency Contact

Full Name:		Primary Phone:	
Relationship to patient:		Secondary or Email:	

Financial Responsibility

Who is the guarantor? (Who will be responsible for paying?) For example, if the patient is a minor, this might be a parent. If you were planning to file a claim on an insurance policy your spouse has through their employer, this would be your spouse's info.

❒ Same as above (***If you are the patient and will be responsible for the finances, check the box and continue to next page***).

Guarantor Name and Address

First Name:		Address:	
Initial:		City:	
Last Name:		State:	
Date of Birth:		Zip code:	

Guarantor Contact and Personal Info

Primary Phone:		Driver License:		State issued:	
Secondary Phone:		Social Security:			
Email Address:		Gender:	❒ Male ❒ Female		
Employer:		Marital:	❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed		
Employer Phone:		Relationship:	❒ Spouse ❒ Parent ❒ Legal Guardian ❒ Other _________		

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Policies

All patients must complete our Information forms before seeing the doctor.

General Consent

I hereby give my consent for medical/psychiatric treatment by D. Victoria Martin, M.D. ___________ (Initial)

Release of Information and Telephone Contact

I acknowledge that I must sign an individual Authorization For The Release Of Information form for each person, professional or entity requesting any verbal or written communication pertaining to patient's treatment before Dr. Martin will release said information.

I authorize that messages may be left for me about appointment reminders or instructions regarding my care at the primary or secondary phone numbers designated on the Registration Form. Our office will make NO mention of psychiatry. I agree to update Dr. Martin's office if and when these contact numbers change.

Financial

Please understand that payment of your bill is considered a part of your treatment. Adult patients are responsible for full payment at time of service. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at the time of service. Any minor under the age of 16 will not be seen unless accompanied by an adult.

- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS

The following is a brief, non-comprehensive, listing of services (some fees may not be recovered by your insurance plan and all fees are subject to occasional change without notice):

Initial Evaluation	$350.00
Medication Therapy	100.00
C2 Med Refill	10.00
Missed appointment or late cancellation fee	50%
Records processed for transfer	35.00
Returned checks (NSF)	25.00
Unusual amount of time authorizing meds with your insurance carrier	25.00
Written correspondence to employer or school	25.00
Replacement of lost or expired prescriptions	10.00

Regarding Insurance

We will provide you with documentation from each visit to assist you in filing your claims. Dr. Martin does not accept assignment of benefits and no longer participates in any network. Your insurance plan will reimburse you directly. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We have no agreements to offer discounts for specific plans.

Office staff will make reasonable attempts to pre-certify medications. However, we must ask that you take responsibility for getting us necessary information. This includes your insurance ID and group numbers and mainly, a direct telephone number to the pre-certification department (not Customer Service!). If you get a phone number from your pharmacist, please confirm the number is for providers, not pharmacists.

Missed Appointments

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of 50% of the regular fee. Please help us to serve you better by keeping scheduled appointments.

Confidentiality

Dr. Victoria Martin's office is fully compliant with current HIPPA guidelines. A copy of our HIPPA Statement is included in this packet and is also available upon request from our receptionist.

Your signature specifies that you have read all of the above. You've had a chance to read our HIPPA Statement and that you understand and agree to be bound by all policies contained in this document.

________________________ Signature   ________________________ Printed name   ________________________ Date

Please let us know if you have questions or concerns.

D. Victoria Martin, M.D.

Credit Card Authorization

Name on Card	Patient name (if different)

Card #	Exp Date	Zip Code	Street #	Security Code#

I hereby authorize the above credit account be used for payments owed Dr. Victoria Martin for fees and services incurred by the patient.

Signature: ____

Date: ____

Several reasons to leave your credit card info on file with us:

- If your young adult (18 or over), is coming in for medication management and you would still like to option to pay for their visits.
- If your spouse is paying, but doesn't always come with you.
- If you have a check returned to us unpaid because of insufficient funds of a checking account, or moved your account to another bank but inadvertently wrote a check on the closed account.
- If you just don't want to deal with payment when you came in.

** This agreement may be cancelled in writing at any time.

** Please inform us if and when this information changes.

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Developmental and Social History (18 and Above)

Family Background and Childhood History: What is your current age? ______ Where were you raised? __________________

Were you adopted? Yes ❑ No ❑ List your brothers and sisters and their ages: ____

Father's Occupation: __________________________________ Mother's Occupation: ____

Did your parents divorce? Yes ❑ No ❑ If so, how old were you? ______ How old were you when your father remarried? ______

How old were you when your mother remarried? ______ Describe your father and your relationship with him: __________________

____

Describe your mother and your relationship with her: ____

____

How old are your parents currently? Dad: ______ Mom: ______ How old were you when you left home? __________________

Has anyone in your immediate family died? Yes ❑ No ❑ Who and when? ____

Were you ever physically or sexually abused? Yes ❑ No ❑ If so, at what age(s)?____________ By whom? _________________

Educational History: Did you enjoy school? ____

What kind of grades did you make in school? _______________ Describe your social life at school: ___________________________

____

What things got you in trouble at school? ____

Did you attend college? Yes ❑ No ❑ Where? ____________________ What was your Major? ___________________________

Highest educational level or degree attained? ________________

Occupational History: Are you currently working? Yes ❑ No ❑ How long in current position? ___________________________

What is your occupation? ____________________________ Where do you work? ____

Where have you worked before and for how long? ____

Marital Status/Current Family: Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

How long in current status? ______ If married, what is your spouse's occupation? ___________________ Describe your relationship with your spouse or significant other: ____

Have you had any previous marriages? Yes ❑ No ❑ If so, how many? _______ For how long each? _________________________

Do you have children? Yes ❑ No ❑ Names and ages: ____

Religion: What is your religious affiliation? __________________________ Where do you attend services? ____________________

For how long? _________________ Do you attend regularly? Yes ❑ No ❑ Please rate the importance of your religion or spiritual beliefs in your life: All important ❑ Very important ❑ Important ❑ Somewhat important ❑ I never even think about it ❑

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Health History: (18 and Above)

Medical Health History:

Who is your Primary Care Physician? ______________________________ When was your last appointment? ______________________

List any medical problems or surgeries?____

Have you ever had any sort of heart problems? Yes ❑ No ❑ If Yes, explain: ____

For Women: Date of last menstrual period: __________________ Method of contraception: ____________________________

Is there any possibility that you are pregnant? Yes ❑ No ❑ Are you considering pregnancy? Yes ❑ No ❑

Please list all medications you are currently taking. (Include Vitamin and/or herbal):

	Medication	Dose (mg)	Times per day	mo/yr started
1.				
2.				
3.				
4.				
5.				

Please list any medications you are allergic to: ____

Mental Health History:

Please list previous psychiatrist, psychologist or therapists you have seen.

	Person seen	Dates seen	Meds Prescribed	Reason Seen	Hospitalized where?
1.					
2.					
3.					
4.					

Family History:

List any blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) who have any history of any emotional problems (depression, manic-depression, anxiety, schizophrenia, drug/alcohol abuse, suicide.)

	Relation	Side of Family	Problem	Hospitalized
1.		Mother ❑ Father ❑		Yes ❑ No ❑
2.		Mother ❑ Father ❑		Yes ❑ No ❑
3.		Mother ❑ Father ❑		Yes ❑ No ❑
4.		Mother ❑ Father ❑		Yes ❑ No ❑

Substance Abuse:

Do you smoke? Yes ❑ No ❑ How much? _______________ How long? __________________ Do you drink? Yes ❑ No ❑

Times per month? __________ In an average week? ____________ Have you ever felt you were drinking too much? Yes ❑ No ❑

Have you ever tried unsuccessfully to stop drinking? Yes ❑ No ❑

Have you ever used any of the following?

Marijuana ❑ Amphetamine ❑ PCP ❑ Crack ❑ Cocaine ❑ LSD ❑ Ecstasy ❑ Cheese ❑

Have you ever felt you had a problem with any of the above drugs? Yes ❑ No ❑ Have you ever used drugs I.V.? Yes ❑ No ❑

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Adult ADHD Rating Scale:

For each of the following statements, mark the box under "YES", "SOME" or "NO" depending upon which fits you best. (All statements must be answered).

		YES	SOME	NO
01.	I fail to pay close attention to details or I tend to make careless mistakes	❑	❑	❑
02.	I have difficulty sustaining attention	❑	❑	❑
03.	I often find I have failed to listen or have read a paragraph and don't know what I have read	❑	❑	❑
04.	I have difficulty finishing tasks, or I have multiple projects going at the same time	❑	❑	❑
05.	I have difficulty organizing tasks and activities	❑	❑	❑
06.	I often misplace or lose items	❑	❑	❑
07.	I am easily distracted by extraneous stimuli	❑	❑	❑
08.	I often seem forgetful or absent-minded, even regarding daily activities	❑	❑	❑
09.	I often fidget with my hands and feet	❑	❑	❑
10.	I feel "on the go" as if I am driven by a motor	❑	❑	❑
11.	I interrupt conversation or blurt out answers before questions have been completed	❑	❑	❑
12.	I am impatient and I have trouble waiting	❑	❑	❑
13.	I feel that I have failed to accomplish what I'm capable of	❑	❑	❑
14.	I procrastinate (put things off)	❑	❑	❑
15.	I am a risk taker	❑	❑	❑
16.	I get bored easily	❑	❑	❑
17.	I have a history of impulsive behavior	❑	❑	❑
18.	I have frequent and dramatic mood swings	❑	❑	❑
19.	I have difficulty settling down at night and going to sleep	❑	❑	❑
20.	I struggle with low self-esteem	❑	❑	❑
21.	I have experienced these problems since childhood	❑	❑	❑
22.	I had problems in school because of these characteristics?	❑	❑	❑

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Adult Anxiety Ratings Scale

Please read and reflect on each statement below. After each statement, select one of the five responses that best fit you. Please respond to each statement.

		None	Little	Moderate	Severe	Incapacitating
01.	I have experienced palpitations, pounding heart or accelerated heart rate.	❑	❑	❑	❑	❑
02.	I have experienced excessive sweating.	❑	❑	❑	❑	❑
03.	I have experienced trembling or shaking.	❑	❑	❑	❑	❑
04.	I have experienced sensations of shortness of breath or smothering.	❑	❑	❑	❑	❑
05.	I have experienced a sensation of choking.	❑	❑	❑	❑	❑
06.	I have experienced chest pain or discomfort.	❑	❑	❑	❑	❑
07.	I have experienced nausea or abdominal distress.	❑	❑	❑	❑	❑
08.	I have felt dizzy, unsteady, lightheaded or faint.	❑	❑	❑	❑	❑
09.	I have experienced feelings of unreality or depersonalization (feeling detached).	❑	❑	❑	❑	❑
10.	I have experienced fear of losing control or going crazy.	❑	❑	❑	❑	❑
11.	I have experienced fear of dying.	❑	❑	❑	❑	❑
12.	I have experienced numbness and/or tingling.	❑	❑	❑	❑	❑
13.	I have experienced chills or hot flashes.	❑	❑	❑	❑	❑
14.	I have experienced fear about being in places or situations where escape might be difficult or embarrassing.	❑	❑	❑	❑	❑
15.	I have experienced recurrent and persistent thoughts that are interpreted as intrusive and inappropriate, that cause marked stress, and that are not simply excessive worries about real life problems.	❑	❑	❑	❑	❑
16.	I engage in repetitive behaviors (e.g. hand washing, re-checking) or repetitive thoughts (e.g. counting, repeating words) aimed at reducing stress, which is not connected in a realistic way to the stress, which I aimed at reducing.	❑	❑	❑	❑	❑
17.	The behaviors mentioned in the above two questions are stress producing or time consuming (taking more than one hour per day) or interfere with my normal routine, occupation, or social activities.	❑	❑	❑	❑	❑
18.	I have suffered from excessive anxiety more days than not for at least 6 months about a number of events or activities.	❑	❑	❑	❑	❑
19.	I find it difficult to control anxiety.	❑	❑	❑	❑	❑
20.	I suffer from anxiety associated with restlessness, being easily tired, difficulty concentrating, irritability, muscle tension or sleep disturbance.	❑	❑	❑	❑	❑
21.	Anxiety interferes with my normal routine, occupation, or social activities.	❑	❑	❑	❑	❑

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Zung Depression Scale for Adults:

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days. * It's important to answer all 20 questions! If your answer would be *"none"*, then select *"A little of the time"*

	A little of the time	Some of the time	Good part of the time	Most of the time	Score
1. I feel down-hearted and blue					
2. Morning is when I feel the best					
3. I have crying spells or feel like it					
4. I have trouble sleeping at night					
5. I eat as much as I used to					
6. I still enjoy sex					
7. I notice that I am losing weight					
8. I have trouble with constipation					
9. My heart beats faster than usual					
10. I get tired for no reason					
11. My mind is as clear as it used to be					
12. I find it easy to do the things I used to					
13. I am restless and can't keep still					
14. I feel hopeful about the future					
15. I am more irritable than usual					
16. I find it easy to make decisions					
17. I feel that I am useful and needed					
18. My life is pretty full					
19. I feel that others would be better off if I were dead					
20. I still enjoy the things I used to do					

Office Use Only: Standard range (50 – 69) **In Range: YES** **Out of Range : YES** Total:

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(KEEP FOR YOUR RECORDS)

HIPAA NOTICE OF PRIVACY PRACTICES

I. **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.**

II. **IT IS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).** The law requires that your PHI is kept private. The PHI constitutes information created or noted by this office that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. This Notice about privacy procedures is required. This Notice must explain when, why, and how your PHI would be used and/or disclosed. Use of PHI means when information is shared, applied, utilized, examined, or analyzed within this office; PHI is disclosed when information is released, transferred, given, or otherwise revealed to a third party outside my practice. With some exceptions, your PHI will not be used or disclosed more than is necessary to accomplish the purpose for which the use or disclosure is made; however, following the privacy practices described in this Notice is always legally required. Please note that the right to change the terms of this Notice and these privacy policies at any time is reserved. Any changes will apply to PHI already on file in this office. Before any important changes to policies are made, this Notice will be modified and a new copy of it posted in the office and on the website. You may also request a copy of this Notice from the office, or you can view a copy of it in the office or the website, which is located at http://www.victoriamartinmd.com/ . For purposes of this Notice, the use of the word "office" should be taken to mean Dr. Victoria Martin, M.D. and her entire office staff. In all cases when the words "you" or "patient" are used, it should be taken to mean "the patient or their parent/legal guardian."

III. **HOW YOUR PHI WILL BE USED AND DISCLOSED.** Your PHI will be used and disclosed for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. Your PHI may be used and disclosed without your consent for the following reasons:

1. For treatment. Your health information may be used to give you medical treatment or services. Your health information may be disclosed to pharmacists and their assistants, and other professionals involved in your care to put in place a treatment plan and to carry out that plan. For example, if you or your child has ADHD, the doctor, or office staff may need to clarify medication instructions with the pharmacy; obtain prior authorization for certain medications from insurance entities; tell the school nurse when to dispense medication. In some situations, your health information may be disclosed to other health care facilities or providers who will be treating you. For example, we may disclose health information about you to people outside of this office who provide follow-up care to you, such as physicians and in-patient treatment facilities.
2. For health care operations. Your PHI may be disclosed to facilitate the efficient and correct operation of this practice. Examples: Quality control - Your PHI might be used in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. Your PHI may also be provided to attorneys, accountants, consultants, and others to make sure of compliance with applicable laws.
3. To obtain payment for treatment. Your PHI may be used and disclosed to bill and collect payment for the treatment and services provided to you. Example: Your PHI might be communicated to your insurance company or health plan in order to get payment for the health care services that have been provided to you. Your PHI may also be provided to business associates, such as billing companies, claims processing companies, and others that process health care claims for this office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that this office attempts to get your consent after treatment is rendered. In the event that this office tries to get your consent but you are unable to communicate (for example, if you are unconscious or in severe pain) but is reasonable to assume that you would consent to such treatment if you could, your PHI may be disclosed.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. Your PHI may used and/or disclosed without your consent or authorization for the following reasons:

1. For treatment. Your health information may be used to give you medical treatment or services. Your health information may be disclosed to pharmacists and their assistants, and other professionals involved in your care to put in place a treatment plan and to carry out that plan. For example, if you or your child has ADHD, the doctor, or When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: This office may make a disclosure to the appropriate officials when a law requires reporting information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Texas Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Texas Child Abuse and Neglect Reporting law. For example, if there is a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Texas Elder/Dependent Adult Abuse Reporting law. For example, if there is a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell this office of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, giving information about you to the county coroner may be needed.

11. For health oversight activities. Example: This office may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: PHI of military personnel and veterans may be disclosed under certain circumstances. Also in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, PHI may be provided in order to conduct medical research.
14. For Workers' Compensation purposes. PHI may be provided in order to comply with Workers' Compensation laws.
15. Appointment reminders and health related benefits or services. Examples: PHI may be used to provide appointment reminders. PHI may be used to give you information about alternative treatment options, or other health care services or benefits offered.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law.

C. **Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections.** IIIA, IIIB, and IIIC above, your written authorization will be requested before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

These are your rights with respect to your PHI:

A. **The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. You will receive a response from me within 15 days of my receiving your written request. Under certain circumstances, your request may be denied. If so you will receive the reason for denial in writing. You also have the right to have the denial reviewed. There will be a charge for copying your PHI.

B. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that use and disclosure of your PHI be limited and how. While your request will be considered, this office is not legally bound to agree. If your request is agreed to, those limits will be put in writing and abided to except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

B. **The Right to Choose How Your PHI is Sent to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). This office is obliged to agree to your request providing that the PHI can be rendered, in the format you requested, without undue inconvenience.

C. **The Right to Get a List of the Disclosures Made.** You are entitled to a list of disclosures of your PHI made by this office. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. Your request for an accounting of disclosures will be responded to within 60 days of receiving your request in writing. The list will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. The list is offered to you at no cost, unless you make more than one request in the same year, in which case a reasonable sum will be charged based on a set fee for each additional request.

D. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request correction of the existing information or addition of the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of receipt of your request. Your request may be denied, in writing, if: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of the records, or (d) written by someone other than this office. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and the denial be attached to any future disclosures of your PHI. If your request is approved, the change(s) will be made to your PHI. Additionally, you will be told that the changes have been made, and all others who need to know about the change(s) to your PHI will be advised.

V. HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If, in your opinion, your privacy rights have been violated, or if you object to a decision made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about privacy practices, no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: D. Victoria Martin, M.D. P.A., 1221 Abrams Road, Suite 100, Richardson, Texas 75081 --- (972) 994-0540, or office@victoriamartinmd.com.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.