Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY DFW SPORTS MEDICINE, PLLC WHETHER MADE BY THE COMPANY OR AN ASSOCIATED FACILITY.

Uses and Disclosures

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

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

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our company. For example, information on the services received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

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

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

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the

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authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

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

Fundraising. Unless you request us not to, we may use your name and address to support our fundraising efforts, if any. If you do not want to participate in fundraising efforts, please check off the following box.

( ) Please do not use my information for fundraising purposes.

Individual Rights
You have certain rights under the federal privacy standards. These include the following and are explained in greater detail in the **PATIENT RIGHTS** section of this notice:

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

Duties of the Company
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlines in this notice.

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

we maintain.

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

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Rathna Nuti, MD
DFW Sports Medicine, PLLC
4833 Medical Center Dr 6E
McKinney, TX 75069
Or
1850 Lakepointe Dr, Ste 700
Lewisville, TX 75057

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

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is as noted above. You may call our Privacy Officer at 469-430-9380.

Effective Date
This notice is effective on or after January 1, 2016.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS COMPANY REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records or others related to

you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Privacy. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

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

Right to Amend

If you feel that the medical information we have about you in your record is incorrect or incomplete, they you may ask us to amend the information by following the procedure below. You have the right to request an amendment for as long as the company maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

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

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the company;
- is not part of the information which you would be permitted to inspect and copy; or
- is inaccurate and incomplete

Right to an Accounting of Disclosures

You have the right to request and "accounting of disclosures". This is a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period no longer than six (6) years back and may not include dates before January 1, 2016 (or the actual implantation date of the HIPPA Privacy Regulations). Your request should indicate in what form you want the list (ie. Paper or electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is expected from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing and your request must indicate:

- what information you want to limit;
- whether you want to limit our use, disclosure or both; and
- to whom you want the limits to apply (i.e., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voicemail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

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DFW Sports Medicine

Acknowledgement of Receipt of Notice of Privacy Practices

DFW Sports Medicine, PLLC reserves the right to modify the right to modify the privacy practices outlined in its notice.

Signature
I have received a copy of the Notice of Privacy Practices from the company referenced above.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

Please sign below **ONLY** if you are **DECLINING** your Notice of Privacy Practice.

I acknowledge that I have declined to receive of review the Notice of Privacy Practices offered by DFW Sports Medicine. I also understand that by signing I waive the rights listed in previous sections. I agree and understand that I do not have to sign this acknowledgement in order for me/the patient to receive treatment by DFW Sports Medicine.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

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