2023

Dr. Claire E. Brenner
Infectious Disease Specialists
2241 Peggy Lane – Suite E – Garland, Texas 75042
Phone 972-494-1155 • Fax 972-494-6572

PATIENT INFORMATION FORM

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep ☐ Life Partner

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White / Caucasian ☐ Black / African American ☐ Amer. Indian ☐ Asian ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese Other: _____

Home Address: _____ Apt/Lot # _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

** Email Address **(necessary for portal access & messaging the office):**

_____

Occupation _____ Employer _____

Person to Notify in Case of Emergency (name & phone number) _____

Preferred Pharmacy Info (Name, Phone Number, Fax Number, & City):

Local Pharmacy: _____

Mail Order Pharmacy: _____

Primary Care Doctor Name & Phone number: _____

Who referred you to our office: ☐ Family/Friend ☐ Self ☐ ER/Hospital: _____

☐ Doctor's Name: _____

If we need to reach you by phone and there is no answer, can we leave you a detailed message? ☐ Y ☐ N

If we need to send correspondence to the address listed, can we mail documents to you? ☐ Y ☐ N

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Appointment Reminders: **(CHOOSE ONE)****

How do you want to be reminded of appointments? **This is computer generated. If this method fails, you will not receive a reminder. Please keep track of all appointments.**

☐ Text Message to this phone number: _____

☐ Phone call to this phone number: _____

☐ Email sent to this email address: _____

If the patient is a MINOR (less than 18 years of age) please list name / names of people responsible for decision making / billing:

Name of Person(s) Authorized	Relationship to Patient	Date of Birth or last 4 # of social security number	Phone number

Patient Authorization to Release Information

I give authorization to the following person(s) to discuss my medical care, appointments, and billing account information with any staff member of the above listed office. I may revoke this authorization at any time by written request.

Name of Person Authorized	Relationship to Patient	Date of Birth or last 4 # of social security number

I have also been given a copy of the clinic policies. I have read these policies and do not have any questions regarding them.

I understand that this office DOES NOT verify insurance benefits before / after my appointment.

I acknowledge that it is my responsibility to make sure that the provider I am seeing is in network with my insurance.

I understand that it is my responsibility to keep the office updated on any insurance changes.

It is the responsibility of the patient to obtain a referral from their primary care provider if one is required.

I understand that appointment reminders are computer generated. If this method fails, you will not receive a reminder.

I understand that it is my responsibility to keep up with all scheduled visits.

I understand that I will be charged $75 for any no call / no shows or cancellations with less than 24-hour notice.

I understand that after 3 no call / no shows I may be terminated from the practice and will be asked to find another doctor.

_____ _____

Patient Signature Date

NEW PATIENT MEDICAL HISTORY

Patient's Name: _____

DOB: _____

Main Reason for Today's Visit: _____

PERSONAL PAST MEDICAL HISTORY

☐ ALCOHOLISM	☐ CHRONIC SINUSITIS	☐ HEART VALVE DISEASE	☐ SARCOIDOSIS	☐ ABNORMAL WEIGHT **LOSS**
☐ ANEMIA	☐ CIRRHOSIS OF LIVER Cause _____	☐ HEPATITIS TYPE _____	☐ SEIZURES	☐ ABNORMAL WEIGHT **GAIN**
☐ ARTHRITIS	☐ COPD / EMPHYSEMA	☐ HERPES INFECTION ☐ Oral ☐ Genital	☐ SHINGLES	☐ HERNIA TYPE _____
☐ ARTIFICIAL JOINTS OR HARDWARE PLACEMENT	☐ CYSTIC FIBROSIS	☐ HIGH BLOOD PRESSURE	☐ SKIN INFECTIONS	☐ VISION ISSUES
☐ ASTHMA	☐ DEMENTIA	☐ HIGH CHOLESTEROL	☐ STROKE	☐ HEARING ISSUES
☐ BLEEDING DISORDER	☐ DIABETES TYPE 1 ☐ OR 2 ☐	☐ HIV / AIDS Diagnosed in: _____	☐ DEPRESSION	OTHER: _____
☐ BLOOD TRANSFUSION	☐ DRUG ADDICTION CHEMICAL DEPENDANCY	☐ KIDNEY DISEASE / FAILURE	☐ ANXIETY	_____
☐ BONE INFECTION / OSTEOMYELITIS	☐ ENDOCARDITIS	☐ LYME DISEASE	☐ SUICIDE ATTEMPT	_____
☐ CANCER type _____	☐ GALLBLADDER DISEASE	☐ MENINGITIS	☐ THYROID ISSUES ☐ HYPER ☐ HYPO	_____
☐ COUGH	☐ GOUT	☐ PANCREATITIS	☐ MIGRAINES	_____
☐ CHRONIC BRONCHITIS	☐ HEART ATTACK	☐ PNEUMONIA	☐ TUBERCULOSIS ☐ ACTIVE ☐ LATENT	_____
☐ LUPUS	☐ HEART FAILURE	☐ PROSTATE ISSUES	☐ URINARY TRACT INFECTIONS	_____
☐ NON HEALING WOUNDS	☐ RHEUMATIC FEVER	☐ PSYCHIATRIC CARE	☐ STD TYPE: _____	

Type of SURGERIES / HOSPITALIZATIONS	Repair / Replacement of (if applicable):
	☐ right ☐ left ☐ both
	☐ right ☐ left ☐ both
	☐ right ☐ left ☐ both
	☐ right ☐ left ☐ both
	☐ right ☐ left ☐ both

HEALTH HABITS

Alcohol	☐ Yes ☐ No	☐ Current User ☐ Former User stopped _____ years ago ☐ Never Used ☐ social drinker ☐ daily drinker for _____ years
Street Drugs:	☐ Yes ☐ No	☐ Current user ☐ Former user ☐ Never Used Use / used _____ for _____ years
Tobacco:	☐ Yes ☐ No	☐ Current user _____ packs per day ☐ E-Cig ☐ Smokeless Tobacco – Snuff , Dip or Chew ☐ Former user stopped _____ years ago used for _____ years ☐ Never used

FAMILY HISTORY

Please list information for any family member (parents and/or siblings) who has ever had any of the following:

Mother ☐ Alive ☐ Deceased	☐ High Blood Pressure ☐ Cancer _____ ☐ Stroke ☐ Heart Disease ☐ High Cholesterol ☐ Thyroid ☐ Diabetes type _____ ☐ Recurrent Infections ☐ Other: _____
Father ☐ Alive ☐ Deceased	☐ High Blood Pressure ☐ Cancer _____ ☐ Stroke ☐ Heart Disease ☐ High Cholesterol ☐ Thyroid ☐ Diabetes type _____ ☐ Recurrent Infections ☐ Other: _____
Siblings	☐ High Blood Pressure ☐ Cancer _____ ☐ Stroke ☐ Heart Disease ☐ High Cholesterol ☐ Thyroid ☐ Diabetes type _____ ☐ Recurrent Infections ☐ Other: _____

PREVENTIVE MEDICINE QUESTIONS:

DATE OF LAST	WOMEN ONLY
Date of last Colonoscopy:	Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure
Date of last Flu Shot:	Date of last Mammogram:
Date of last Pneumonia Shot:	Date of last Pap Smear: ☐ Normal ☐ Abnormal
Date of last Tetanus Shot:	Date of last Menstrual Cycle:
Date of last Bone Density Study:	Have you had a broken bone in the last 6 months? ☐ Yes ☐ No
Diabetic Patients only: Date of last Diabetic Eye Exam: Date of last Diabetic Foot Exam:	

ARE YOU EXPERIENCING ANY PAIN? ☐ Yes ☐ No

IF SO, WHAT IS YOUR PAIN LEVEL ON A SCALE OF 1-10 (1 IS MINIMAL PAIN / 10 SEVERE PAIN) _____

Have you ever had a **blood transfusion?** ☐ Yes If so, what year?_____ ☐ No

Medication List

Patient Name: _____ Date of Birth: _____

Medication Name	Dosage	Frequency

Allergies to Medications:

Nausea, vomiting & diarrhea are not considered allergies. They are side effects of the medication.

Examples of allergies to medications are hives, difficulty breathing, rash, and swelling.

Drug Name	Reaction / Issues

_____

Patient Name

Dr. Claire E. Brenner, M.D.

Consent to Use and Disclose Protected Health Information

THE NOTICE OF PRIVACY PRACTICES

We here at **Claire E. Brenner and Associates, M.D., P.A.** understand that your private health information is personal and private. We are committed to the protection or your medical information. We are required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by us or disclosed to others for the purposes of treatment, obtaining payment, supporting the day-to-day health care operations of the practice or appointment reminders. Please see the brochure for more details.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, we may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or **Office Administrator** if you would like additional information or clarification.

It is a violation of the federal privacy standards if we agree and fail to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or **Office Administrator** at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time; however, we require that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES

We reserve the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. We will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method at your request.

SIGNATURE

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **Claire E. Brenner and Associates, M.D., P.A.** to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____

Name of Patient (Print or Type) **Signature of Patient/Date**

_____ _____

Patient Representative (Print or Type) **Signature of Representative/Date**

_____

Relationship of Patient Representative to Patient

Consents and Authorizations

Provider: We must emphasize that as medical care providers our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, your employer, and the insurance company. We are not a party to your contract. (This does not pertain to carriers with whom we have HMO/PPO contracts).

Consent to Treatment: I hereby grant all physicians and nurse practitioners at Claire E. Brenner and Associates, M.D., P.A. the authority to treat and examine me/my dependent and order the examination, test, treatment, and other clinical services necessary for my care and treatment.

PLEASE INITIAL_____

Insurance Authorization: I hereby authorize Claire E. Brenner and Associates, M.D., P.A. to furnish my insurance carrier with information concerning my illness and treatment. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I also authorize electronic transmission of my insurance claim to the carrier. **PLEASE INITIAL**_____

Medicare Assignment: I hereby request that payment of authorized Medicare Benefits be made to Claire E. Brenner and Associates, M.D., P.A. for services provided. **PLEASE INITIAL**_____

Consent to Release Medical Records: I hereby authorize Claire E. Brenner and Associates, M.D., P.A. permission to release medical records or patient information to all referring physicians, hospitals, and auxiliary services referred by this practice, or firms that have been your representative.

PLEASE INITIAL_____

Consent to Electronically Transmit (FAX): I hereby authorize Claire E. Brenner and Associates, M.D., P.A. permission to electronically transmit (FAX) copies of medical records or patients' information to all referring physicians, hospitals, and auxiliary services referred by this practice. It is my understanding that there are instances when electronically transmitted information may go somewhere other than the number dialed due to switching malfunctions at the phone company and Claire E. Brenner and Associates, M.D., P.A. will not be held responsible. **PLEASE INITIAL**_____

Reasonable and Customary: I understand that Claire E. Brenner and Associates, M.D., P.A. is a group of specialists and that fees charged may be more than what my insurance carrier considers reasonable and customary. I understand that if my insurance company fails to pay, Claire E. Brenner and Associates, M.D., P.A. will not be held responsible. **PLEASE INITIAL**_____

Missed Appointments / No Call / No show policy: I am aware that I will be charged $75 for missed appointments not cancelled 24 hours in advance. In the event a patient has incurred three documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from the practice. **PLEASE INITIAL**_____

Acknowledgement of receipt of office policies and HIPAA disclosure – I have been given a copy of the clinic's office policies along with the office's HIPPA disclosure. I have read these policies and do not have any questions regarding the policies.

PLEASE INITIAL_____

Medication Policy: Please allow 24 hours for all medication refills. **Patients should contact their pharmacy for refills. Medications will not be filled on the weekend or after hours.** We are unable to refill prescriptions if the patient does not follow up with their doctor as recommended. **HIV patients must be seen every 6 months to have their medication refilled.** HIV medications should be requested 7-10 days prior to your last dose. Most pharmacies don't usually keep those medications on their shelf and many times will have to order them from their distributor so there will be a delay in filling your prescription. Those patients requiring long term pain medications will be referred to a pain management specialist for all medication needs.

Permission to Leave Messages on Answering Machine: By signing below you authorize us to leave messages regarding appointment reminders, referral information, etc. on the numbers/email address listed below.

Email Address:_____

Phone Number (_____)_____-_____ Phone Number (_____)_____-_____

Signed:_____Dated:_____

Payment of Office Visit: Copayment must be rendered in full at the time of your visit.
Payments may be made in the form of cash, check, American Express, Discover, MasterCard, or Visa. A $50.00 service fee will be charged on all returned checks. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to the medical practice. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of the medical practice, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that I can revoke at anytime except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Additionally, I acknowledge that I fully comprehend the consents and authorizations and that any questions I had were discussed with my physician and/or the staff. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered; patient will not be provided medical care except in a case of emergency.

_____ _____
Name of Patient (Print or Type) **Signature of Patient/Date**

_____ _____
Patient Representative (Print or Type) **Signature of Representative/Date**

_____
Relationship of Patient Representative to Patient

Acknowledgment of Notice of Privacy Practices
Patient Financial Policy

Pt. Name _____
DOB_____

We are committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policy.

Healthcare providers and patients each have a unique relationship with insurance carriers and different sets of responsibilities.

It is Your Responsibility:
• To know your insurance policy. You need to be aware of your benefit coverage prior to your appointment. You should obtain information from your insurance carrier regarding contracted physicians with your plan, covered and non-covered benefits, authorization requirements, and cost share information, including deductibles, coinsurance, and co-pays. You will be held responsible for these personal balances, so it is a good idea to know your plan prior to receiving services. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier directly. We do not verify benefits prior to your appointment.
• To ensure that a referral from your Primary Care Physician (PCP) has been received, and/or confirm that an authorization for treatment has been obtained from your insurance carrier, prior to receiving services, if such authorization is required. Any service subsequently found to be non-covered is your financial responsibility.
• To pay your co-pay in full at the time of service.
• To pay any Medicare deductible and co-insurance amounts not covered by your supplemental insurance.
• To promptly pay any patient responsibility indicated by your insurance carrier.
• To facilitate in claims payment by contacting your insurance carrier when claims are not paid in a timely manner.
• To give at least 24 hours' notice of cancellation prior to appointments. If you do not show up for an appointment and did not cancel the appointment with at least 24 hours' notice, you will be charged a $75 No-Show fee that must be paid prior to your next appointment. To understand that this charge is not reimbursable by health insurance, Medicare or Medicaid. If you consistently do not show up for / cancel appointments, or do not give adequate notice of cancellation, you may be discharged from future care with Dr. Brenner.
• To understand that there is a $25 fee for the completion of various forms including but not limited to FMLA and disability. To also understand that this is not a charge that is reimbursable by health insurance, Medicare or Medicaid.

It is Our Responsibility:
• To provide quality medical care to all of our patients regardless of insurance coverage.
• To comply with all applicable HIPAA privacy rules, and to provide all patients with a Notice of Privacy Practices.
• To file claims with insurance companies with whom we are contracted. As a courtesy to you, we may file other commercial claims, but only with primary and secondary carriers. A 60-day period will be allowed for pending insurance payments, after which you may be held responsible for the balance.
• Dr. Brenner's staff cannot be responsible for providing detailed insurance coverage and benefit information to you. We are not knowledgeable about all of the many insurance plans our patients may be covered with. We will do our best to assist you with your questions; however, you should contact your insurance carrier to obtain detailed information regarding your coverage and benefits.

I have read and understood the above financial policy. I understand that I am responsible for knowing and following the guidelines of my insurance policy to facilitate payment for services rendered.

Patient Name (please print):	
Signature:	Date:

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature:	Date:

Dr. Claire E. Brenner Infectious Disease Specialists
2241 Peggy Lane – Suite E – Garland, Texas 75042
Phone 972-494-1155 • Fax 972-494-6572

Insurance Information:

I understand that this office DOES NOT verify insurance benefits before / after my appointment. I acknowledge that it is my responsibility to make sure that the provider I am seeing is in network with my insurance. I acknowledge that is my responsibility to obtain any referrals that are required for my visits.

*** Please choose one of the options below: ***

☐ **I have provided my insurance card/cards to the office staff today.**

To the best of my knowledge this is my most current insurance information. I understand that if my insurance information is not accurate, I will be billed for charges that occur. I acknowledge that is my responsibility as the patient to keep this office up to date on all demographic and/or insurance changes.

☐ **I did not bring a copy of my insurance card/cards to my visit today.**

I understand that it is my responsibility to provide accurate up to date insurance information to my provider. If the information, my provider finds on other sources of documentation (hospital / referral records) is incorrect I agree that they will not be held liable, and it will be my responsibility to contact their billing office with the correct insurance information and have any denied / pending claims reprocessed.
I have insurance with the following company/companies

Primary Insurance: _____

Secondary Insurance: _____

☐ **I am a self-pay patient.** I am aware of the office visit charge of $200 for a new patient and $75 for a follow up visit. I also acknowledge that they may be additional charges for any lab work that is ordered. I understand that all charges including labs will be due at the time the service is rendered.

Patient signature: _____

Date: _____

INFECTIOUS DISEASE SPECIALISTS

Dr. Claire E. Brenner, M.D., P.A.

APPOINTMENT GUIDELINES

It is our desire to provide our patients with timely, quality care. To do so, we require our patients to arrive on time and make every scheduled appointment.

We feel as if is it important for our patients to understand our guidelines as it relates to cancellations, no shows for appointments, and late arrivals.

1. If you are NEW to our practice, we ask that you arrive at least 15 min prior to your scheduled appointment time. You will have new patient paperwork to complete. Arriving early allows our staff to efficiently perform their tasks of registering you into our electronic medical record system.
2. For follow-up visits, we ask that you arrive on time. Should you arrive more than 15 minutes late for any scheduled appointment you may be asked to reschedule or moved to a work-in status and seen after all other regularly scheduled patients.
3. We require a 24-hour advance notice if you are not able to keep your scheduled appointment. To cancel or reschedule an appointment please call the office at 972-494-1155 during regular business hours. If your appointment falls on a Monday, you may leave a message with the answering service. If you fail to cancel or reschedule your appointment 24 hours before your scheduled appointment you will be charged a $75 fee. The fee applies to same day cancellations and reschedules. This fee cannot be submitted to your insurance company for payment.
4. If you do not attend your scheduled appointment (no call / no show), you will be charged a $75 fee that is your responsibility to pay. This fee cannot be submitted to your insurance company for payment.
5. Three no call / no shows during a 1-year time frame are grounds for termination from the practice.

I have read and understand the above guidelines for appointment arrivals, cancellations, and no shows.

Patient Signature: _____ Date:_____

Claire E. Brenner, M.D.

UPDATED - OFFICE POLICIES - 2023

Welcome to our office! We look forward to serving you.
We've included information below about our policies regarding common patient needs and concerns.
Please take a moment to read over a general summary of our office and how we operate so we can serve you most efficiently.

Hours of Operation
Normal business hours for appointments /phone calls: Monday – Friday 9am – 4:30 pm.

*** Closed daily for lunch from Noon to 1 pm. ***
We are closed on ALL major holidays and usually the day before or the day after Thanksgiving, Christmas, and New Year.
In situations of inclement weather, we may only be open for a ½ day or not at all.
On bad weather days please contact the office to make sure we are open BEFORE coming to your appointment.

Phone Messages: We do our best to return phone calls throughout the day. The urgency of the issue will determine how rapidly the call is returned. Our staff returns calls as soon as possible. We will make every effort to return your call by the end of the day. If unable to return the call same day we will call you back within 24 hours. It is only necessary to **leave one message**. If your matter is urgent and cannot wait, please make an appointment, or go to an urgent care facility. Same-day appointments are usually available for such circumstances. **Our physicians will not call you back directly.** Your call will be returned by either a medical assistant or a nurse. When leaving a message please leave your FULL name, Date of birth, and a reason for your call.

Appointment/Delays: Our provider works very hard to stay on schedule. Since we are a specialist practice some of our patient visits may run over on time. We appreciate your patience and understanding in these unexpected circumstances.

Cancellations/Re-schedules/Missed Appointments/Late Arrivals: In the event you find that you are unable to make your appointment, please call at least 24 hours in advance to change or cancel the appointment so that we may make that appointment slot available to other patients in need of care. All patients that do not cancel within this time period are subject to a $75 late cancellation fee. Please be aware that 3 or more no call / no shows will cause your dismissal from the clinic. If you are more than 15 minutes late you will be asked to reschedule your appointment.

Evening and Weekend Calls : After hours of operation and on weekends, phone calls are received by our answering service. The answering service will refer your call to the on-call physician if your problem is an emergency. Otherwise, we ask that you call us back during regular business hours. In an emergency, please call 911 or go to the nearest urgent care center. Our practice has a physician on call 24 hours a day, 7 days a week. The answering service cannot make appointments or provide medication refills.

Prescription Refills
Please call your pharmacy for all prescription refills, and remember to call at least 7-10 days in advance of running out of medication or leaving town. Once the pharmacy notifies our office that a refill has been requested, please allow our office 24-72 hours to process your prescription refill request. It is only necessary to call once for a refill. Several phone calls regarding one refill slow the process down. If more than 72 hours have passed since your call to the pharmacy to request your medication, then please call the office. The pharmacy can request your refill submitting a refill via E-Prescribe. **Please note that prescription refill authorizations are contingent upon you maintaining recommended follow-up appointments and/ or lab testing.** We are not able to refill medication for patients that we are not seeing on a regular basis. HIV patients must be seen in the last 6 months to have their medication refilled. Early refills will not be given. Prescriptions that are lost, stolen, or destroyed will not be replaced. **You will be referred to a pain management specialist for all chronic pain issues.**

Lab Test Results

Our office will always notify patient by phone call if test results are abnormal or critical. If you do not receive a call, it is safe to assume your results are normal; however, you are welcome to call at least one week after having any lab or imaging done to confirm your results. Please keep in mind that the doctor may have ordered specialized testing that can take up to 6 weeks to complete. All lab work must be ordered by a doctor. If you are requesting to have another doctor's labs done in our office, you must provide the official written order request from their office.

Medical Records

If you need medical records, please sign and submit a medical release form and allow us 48-72 hours to process. This request may be sent to our fax @ 972-494-6572. Due to the HIPAA Privacy Rule we are unable to release records without a signed consent.

Disability Forms:

These forms are completed on Fridays when we do not have a doctor in clinic, and we are not seeing patients. Due to the amount of time it takes to complete these forms we are unable to complete them at the time of your appointment or while we have patients in the office waiting to be seen. Please be sure that your full name and date of birth are on all of the pages when you bring them to the office or have them faxed to us. Forms with no names on them will not be completed. Forms should be sent to fax number 972-494-6572.

Patient Financial Responsibility

All co-payments are due at time of your visit unless previous arrangements have been made with the Business Manager. Outstanding balances must be paid in partial or full at your visit. Payment plans are available for balances over $100. We accept cash, check, or credit cards. No post-dated checks will be accepted. Any visits denied for lack of primary care referral will be the financial responsibility of the patient. We do not obtain referrals. It is the patient's responsibility to make sure a current referral is on file for all visits. Any questions regarding bills for lab work will need to be directed to the lab company that was used to collect your labs. We DO NOT do lab billing.

Billing Questions:

Our office uses a separate billing company to coordinate billing issues with your insurance company.
If you have a question about a bill received from our practice, please contact our billing company directly:

Ninety Nine Healthcare Management
9101 LBJ Freeway, Suite 710, Dallas, Texas 75243 phone: (972) 792-5700 fax: (972)788-4707

If you are in **IN-Site home IV antibiotic patient (if Denise assists you with your PICC line in the office)** you will need to contact:

Paragon Infusion at
17111 Preston Road, Suite 160
Dallas, TX 75248 phone: (888) 588-1092

If you have a question, comment, or concern that we did not address, please feel free to ask one of our clinical staff at any time. You are always welcome to speak to the Business Manager about any concern or if you have something great to say about our services and any of our staff. We thank you for choosing us as your new medical home and look forward to providing you quality medical care.

Claire E. Brenner, M.D.,
Notice of Privacy Practices for Protected Health Information
Effective Date: 02-17-17

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 office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.

- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;

- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;

- Appeal a denial of access to your protected health information, except in certain circumstances;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. 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 health information kept by or for the office;

    - Is not part of the information that you would be permitted to inspect and copy; or,

    - Is accurate and complete.

    If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact the practice administrator in person or in writing, during regular, business hours. [S]he will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

Practice Administrator
2241 Peggy Lane - Suite E
Garland, Texas 75042

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the practice administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address can be obtained from the practice administrator.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person your identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose 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.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.