G. DeAn Strobel, MD, PA
Hormonal Balance & Wellness
G. DeAn Strobel, MD * Susan Lee Fisher, PA-C * Brooke Lipscomb, PA-C * Angelica Ortiz, NP
230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

Privacy Practice Notification

The Health Insurance Portability & Accountability of 1996 (HIPAA) is a federal program that requires all medical records and other identifiable health information used or disclosed by G. DeAn Strobel, M.D., P.A., in any form, whether electronically, on paper, or oral are kept properly confidential. This ACT gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services including medical laboratories by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Heath care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related issues and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorizations. You may revoke such authorization in writing, and we are required to honor and abide by your written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you may exercise by presenting a written request to our “Privacy Officer.”

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.

- The right to inspect and copy your protected health information. There is a charge of $35 for the first 20 pages and the $.25 per page thereafter for copies.

- The right to amend your protected health information. You must make your request in writing to the privacy manager.

- The right to receive an accounting of disclosure of protected health information. You may request once annually with no charge. There is a $25 charge for all subsequent requests.

- The right to receive a paper copy of this notice upon request.

To file a complaint please notify: “The Department of Health & Human Services Office of Civil Rights”, 200 Independence Ave. S.W., Washington, D.C. 20201 or call 1-877-696-6775.

G. DeAn Strobel, MD, PA
Hormonal Balance & Wellness
G. DeAn Strobel, MD * Susan Lee Fisher, PA-C * Brooke Lipscomb, PA-C * Angelica Ortiz, NP
230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

Consent Form

PLEASE READ AND INITIAL ALL NINE (9) STATEMENTS BELOW

1. I understand that under the Health Insurance Portability and Accountability Act I have certain rights to privacy regarding health information. I have read the Privacy Practice notification provided.
   Initials:_______________

2. I authorize G. DeAn Strobel, M.D., P.A. office to leave messages via my answering machine or voicemail for appointments, reminders, general medical information, test results, billing, and/or referral information.
   Initials:_____________

3. **(Check one option)**
   _____I authorize G. DeAn Strobel, M.D., P.A. to communicate verbally with the following family member or friend:
   ____
   regarding my appointments, test results, general medical information, or referral information. *(Verification to release any information will be by the patient's date of birth.)* If no name is written on the above line, then that means I do not want anyone at all to be able to speak with the clinic about my medical information. (This does not apply to minors.)
   OR
   _____I do NOT authorize the office or staff to speak to anyone other than myself.
   Initials:______________

4. I authorize G. DeAn Strobel, M.D., P.A. to release any medical information needed to determine payment for my services. **Initials:**_______________

5. I authorize G. DeAn Strobel, M.D., P.A. to release protected health information to only HIPAA covered entities (health plans, providers, medical laboratories and healthcare clearinghouses) on my behalf.
   Initials:____________

6. I authorize my insurance carrier to make direct payments on my behalf to G. DeAn Strobel, M.D., P.A. for medical services furnished. **Initials:**______________

7. I am aware I am responsible for co-payments, co-insurance, or any deductible at the time of services.
   Initials:_________________

8. Authorization is valid until rescinded by me in writing. **Initials**:______________

9. I authorize G. DeAn Strobel, M.D., P.A. to evaluate and treat: ______________________________________.
   Initials:_______________ **(Patient Name)**

Patient/Guardian Name:_______________________________________ Date of Birth:______________________

Signature:____Today's date:_______________________

Relationship to patient (if patient is a minor or unable to sign):____