Mary E. Geldernick, M.D.
Patient Registration

Name: *Last* _____ *First* _____ *Middle* _____ Maiden _____

Birthdate: _____ DL# _____ SS#_____ - _____ - _____

Marital Status (Circle) S M D W Student (Circle) Y N Full Time Part Time

Street Address: _____ Mailing Address: _____
(Physical Address of home must be given) *(If different than street address)*

City: _____State:____Zip:_____ City:_____State:____Zip:_____

Phone: *Home ( )* _____
Cell ( ) _____
Work ( ) _____

Check the appropriate box if it is okay to leave normal results at any of the number's listed:

- ☐ *Cell Phone*
- ☐ *Home Phone*
- ☐ *Work Phone*

Abnormal results will not be left as a message

Email: _____

Employer: _____ Pharmacy: _____

Employer Address: _____ Primary Care/Family Doctor: _____

City: _____State:____Zip:_____ Referred By: _____

- ☐ *Full-Time*
- ☐ *Part-Time*

EMERGENCY CONTACT: *Name:* _____ *Relationship:* _____
If unable to reach spouse or parent
Phone: *Home ( )* _____ *Cell ( )* _____ *Work: ( )* _____

**** If under 18 years of age, list responsible parent or guardian's information under spouse's information. ****

☐ *Check if parent or guardian is listed instead of Spouse*

Spouse's *Name: Last* _____ *First* _____ *Middle* _____

Birthdate: _____ Employer: _____

SS#: _____ - _____ - _____ Employer Address: _____

Cell Phone: ( ) _____ City:_____State:____Zip:_____

Work Phone: ( )_____ Ext: _____

Payment Policy: *The patient (or parent/guardian if under 18 and not emancipated) is responsible for all professional services rendered, regardless of insurance coverage. Full payment is expected at the time of service unless other arrangements have been made in advance with our bookkeeper.*

Authorization of Payment: *I hereby authorize Dr. Mary E. Geldernick to release medical information concerning my exam and/or treatment for insurance purposes (including drug and alcohol use and sexually transmitted disease if applicable). I authorize Dr. Mary E. Geldernick to receive direct payment for medical benefits payable to me for services rendered. This authorization is irrevocable unless Dr. Geldernick is otherwise notified in writing prior to services rendered. I certify that the information I have provided is correct.*

Signed: _____ Date: _____
If under 18 years of age, parent or guardian must sign.

We file your insurance as a courtesy.

The law requires insurance companies to send payment or notice of non-coverage within 45 days. If not paid at that time, the charges become *your responsibility.* Please contact your insurance company if you have any questions regarding coverage or your policy.

Most insurance companies define an *Annual Exam* as a physical exam and a pap smear with no problems. Other cultures and blood work may not be covered.

Please Note: If you have problems that require further testing be performed for diagnosis or procedures for treatment, the visit does not meet the criteria for an annual exam. For insurance to consider coverage, it must be filed with a diagnosis (NOT AN ANNUAL EXAM) and is then usually under regular benefits. You may then be partially or entirely responsible for the cost depending on your policy (co-pay, co-insurance or deductible).

Review of systems

Mary E. Geldernick MD 505 North Union Street , New Braunfels Tx.78130

PatientName_____ Date_____

What is the one primary ache, pain or reason for your visit today?

_____

Are you having vaginal bleeding today? _____

☐ To be sure any problems are not overlooked, please fill out the following:

General

What is the most you have weighed in the past year? _____pounds
What is the least you have weighed in the past year? _____pounds

Yes	No	
____	____	Have you had any recent weight loss *without* dieting?
____	____	Do you smoke? If so, number of packs per day: ____
____	____	Do you drink alcohol? If so, number of drinks per week: ____
____	____	Have you ever used drugs?

HEENT

Yes	No	
____	____	In the last six months have you had any unusual, persistent or severe headaches?
____	____	Have you had any head injury, fainting spells or convulsions?
____	____	Have you had any recent change in vision, sense of smell or hearing?
____	____	Do you wear ☐ glasses ☐ contacts?
____	____	Have you had any nosebleeds, ringing in your ears or dizziness?
____	____	Do you wear dentures?
____	____	Have you had any difficulty in breathing or swallowing?
____	____	Have you coughed up blood, spit up blood or vomited up blood?
____	____	Do you sleep on more than one pillow?
____	____	Do you ever wake up at night out of a sound sleep and have to sit up to breathe?
____	____	Does your heart flip-flop or miss a beat?
____	____	Have you had any severe chest pain?
____	____	Do you have heaviness on your chest?
____	____	Do you have any squeezing chest pain?
____	____	Have you had any swelling of your ankles or feet?
____	____	If so, does the swelling go down at night?

Breasts

Yes	No	
____	____	Have you had any lumps in your breasts or any type of nipple discharge?
____	____	Have you ever had a mammogram? If so, when was your last one? ____

OVER⇒

GI

Yes	No	
____	____	Does any type of food give you indigestion, heartburn or diarrhea?
____	____	Have you had any stomach trouble, ulcer or history of irritable bowel syndrome?
____	____	Have you had any change in the size of your stools?
____	____	Have you had any black, bloody or painful bowel movements?
____	____	Are you having problems with constipation?
____	____	Do you have pain with bowel movements at the time of your period?

GU

Yes	No	
____	____	Have you had any blood in your urine?
____	____	Have you had a bladder infection during the past year?
____	____	Have you had any recent burning with urination?
____	____	Do you wet your panties when you cough, sneeze or with lifting?
____	____	Is it getting worse?
____	____	If you void to empty your bladder, does urine dribble out when you stand up?
____	____	Do you lose urine if you hear water running or when washing the dishes?
____	____	Do you lose urine during intercourse?
____	____	If your bladder starts to empty, can you stop it?
____	____	Do you wet the bed at night?
____	____	When you need to void, do you leak before reaching the toilet?
_____		How many times do you urinate during the day?
_____		How many times do you void during the night after going to bed?

GYN

_____	How long ago was your last pap smear?
_____	What type of birth control are you using?
_____	How old were you when you started menstruating?
_____	When was the *first* day of your last period?

Yes	No	
____	____	Have you had any blisters, bumps or sore places on your bottom?
____	____	Have you had any problems with a vaginal discharge creating itch, irritation or odor?
____	____	Have you ever had any sexually transmitted disease?
____	____	Have you had phlebitis or blood clots in a vein?
____	____	Are your periods regular?
____	____	Do you cramp with your periods?
_____		How many days do you flow?
____	____	Did you have any problems with your last menstrual period?
____	____	Are your periods heavy? If so, how many pads per day do you use?_____
____	____	Do you have any bleeding between periods?
____	____	Do you have any bleeding after intercourse?
____	____	Do you have any pain with intercourse?

Patient History

Mary E. Geldernick MD 505 North Union Street, New Braunfels TX 78130

Name: _____ Date: _____

Date of Birth: _____ Primary Care Physician: _____

Emergency Contact that does not live at the same address as you:

Name: _____ Home Phone: ( )_____

Address: _____ Work Phone: ( )_____

Drug Allergies: None

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications: None (Include over the counter)

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History: Check the 1st line if you have had the disease, If 2nd line is present, check only if a blood relative has it.

Self Relative

___ ___ Cancer (list type)
_____
_____
_____

___ ___ Genetic Diseases
_____
_____

EYES AND EARS
___ ___ Glaucoma
___ ___ Meniere's Disease

LUNGS
___ ___ Asthma
___ ___ Emphysema/COPD
___ ___ Pulmonary embolism
___ ___ Tuberculosis

CARDIAC & VASCULAR
___ ___ Anemia
___ ___ Blood transfusion
___ ___ Hemophelia
___ ___ Protein S or C abnormality
___ ___ High Cholesterol
___ ___ High Blood Pressure
___ ___ Mitral Valve Prolapse
___ ___ Heart Attack
___ ___ Congestive Heart Failure
___ ___ Heart Disease at birth

Self Relative

___ ___ Other heart problem
___ ___ Deep Venous Thrombosis

ENDOCRINE
___ ___ Diabetes
___ ___ Thyroid disease
___ ___ Other Endocrine illness

INTESTINAL TRACT AND LIVER
___ ___ Colon Polyps
___ ___ Irritable Bowel/Syndrome
___ ___ Diverticulosis/Diverticulitis
___ GERD/Reflux disease
___ Ulcer
___ ___ Ulcerative Colitis
___ ___ Crohn's Disease
___ ___ Other GI Problem
___ ___ Hepatitis Type _____
___ ___ Cirrhosis

KIDNEYS AND BLADDER
___ Urine Incontinence
___ ___ Interstitial Cystitis
___ ___ Kidney Stones
___ ___ Polycystic Kidney Disease
___ ___ Other Kidney Disease

NEUROLOGIC AND PSCYHIATRIC
___ ___ Multiple Sclerosis
___ ___ Epilepsy/Seizures
___ ___ Stroke
___ ___ Migraine Headaches

Self Relative

___ ___ Severe Head Injury
___ ___ Depression/Bipolar
___ ___ Alcoholism
___ ___ _____

BONE AND JOINT
Bone Fractures _____
_____
___ ___ Fibromyalgia
___ ___ Lupus
___ ___ Rheumatoid Arthritis
___ ___ Osteoporosis

OTHER DISEASE OR ILLNESS
_____
_____

CHILDHOOD ILLNESS & VACCINES
Indicate if you have had the disease or the vaccine for the following:

___ Diptheria ___ Vaccine
___ Measles ___ Vaccine
___ Chicken Pox ___ Vaccine
___ Rubella ___ Vaccine
___ Mumps ___ Vaccine
___ Hepatitis B ___ Vaccine
___ Tetanus ___ Vaccine

Did you have the vaccine in the Flood of 1998?

HABITS: Alcohol
____ # drinks per day
___ less than 2 drinks per week

___ history of treatment for alcoholism

Tobacco
____ #packs per day
___ # years used

___ ex-smoker

Drugs Used in the past 5 years:
___ marijuana
___ cocaine
___ ecstasy
___ acid/LSD
___ heroin
___ prescription drug abuse

Have you ever used IV drugs? ___ yes ___ no

Patient History

Mary E. Geldernick MD 505 North Union Street New Braunfels TX 78130

Name: _____ Date: _____

Surgical History and Hospitalizations: (do not include cesarean or vaginal deliveries)

Procedure	Year	Surgeon	Hospital	do not write in this area

Obstetrical History: P __ __ __ __

☐ Group B Strep Carrier
☐ Cystic Fibrosis Carrier

No. of miscarriages _____: List year(s)_____
No. of abortions_____: List year(s)_____
No. ectopics_____: List year(s)_____
No. deliveries_____: No. of living children_____ (see below)

Year	First Name	Sex (circle)	Delivery Mode (circle one)	Weight	Pre- or Fullterm (no. of weeks)	do not write in this area
		F M	vag c/s		PT FT	
		F M	vag c/s		PT FT	
		F M	vag c/s		PT FT	
		F M	vag c/s		PT FT	
		F M	vag c/s		PT FT	
		F M	vag c/s		PT FT	
		F M	vag c/s		PT FT	

Gynecological History:

Menstrual Periods:

☐ Check here if you have had a hysterectomy or are in menopause with no bleeding for over one year and skip to next page.

Age at first period:_____-years-old
Cycle occurs ☐ once a month (not necessarily on the same day but within 23 to 35 days apart)
☐ irregularly
Bleeding lasts_____days
On heaviest days, I normally use (how many)_____# of ☐ tampons ☐ pads ☐ both at same time

Difficulty with periods? ☐ yes ☐ no If so, specify:

_____

_____

Patient History

Mary E. Geldernick MD 505 North Union Street New Braunfels TX 78130

Name: _____ Date: _____

Gynecological History (continued) please indicate if you have ever had any of these *DIAGNOSED BY A DOCTOR:*

BIRTH CONTROL METHOD

- ☐ None
  - ☐ Abstinence
  - ☐ Menopause / hysterectomy
  - ☐ Attempting to Conceive
- ☐ Vasectomy
- ☐ Tubal Ligation
- ☐ Pill / Patch / Vaginal Ring
- ☐ Depo-Provera Shot
- ☐ IUD
- ☐ Condoms
- ☐ Diaphragm
- ☐ _____

SEXUAL HISTORY

Sexual Preference:

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual

_____Total number partners ever

_____Total # partners in past year

SEXUALLY TRANSMITTED DISEASES

- ☐ None
- ☐ Chlamydia
- ☐ Condyloma / Venereal Warts
- ☐ Herpes
- ☐ Trichomonas
- ☐ Gonorrhea
- ☐ Molluscum Contagiosum
- ☐ Syphiis
- ☐ HIV / AIDS

GYNECOLOGIC CONDITIONS

External Genitals / Vulva:

- ☐ Condyloma
- ☐ Bartholins Abscess or cyst
- ☐ Lichen sclerosis
- ☐ Dysplasia
- ☐ _____

Vagina:

- ☐ vaginal septum
- ☐ imperforate hymen
- ☐ _____

Cervix:

- ☐ Incompetent cervix
- ☐ Abnormal Pap Smear
  - ☐ ASCUS
  - ☐ Dysplasia
  - ☐ Cancer of the Cervix
- ☐ _____

Uterus:

- ☐ Myomas / fibroids
- ☐ Hyperplasia
- ☐ Menorrhagia (heavy bleeding)
- ☐ Polyp
- ☐ Cancer

Ovaries:

- ☐ Polycystic Ovarian Syndrome
- ☐ Teratoma / Dermoid
- ☐ Benign Tumor
- ☐ Cancer

Tubes:

- ☐ Pelvic Inflammatory Disease / PID
- ☐ Endometriosis

DO NOT WRITE IN THIS SECTION

Minor Gynecological Procedures: (list cryosurgery (freezing), LEEP, conization of cervix, drainage of Bartholin's abscess, etc.):

Procedure	Year	Surgeon	do not write in this area

Social History:

Abuse: ☐ Spousal Abuse ☐ Rape ☐ Sexual Abuse

Education: What is the highest level of education you have finished? ☐ Grade ____ ☐ College ☐ Post-University

Current Employment:: ☐ Housewife ☐ retired ☐ unemployed currently ☐ student at _____(list school)

List current occupation: _____

Mary E. Geldernick MD

Diplomat of The American Board of Obstetrics & Gynecology *Fellow of The American College of Obstetrics & Gynecology*

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore, requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellation made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as ***NO SHOW***. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to **a $25.00 fee for office appointment No Show.**

The Cancellations and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (830) 629-6462.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

505 North Union Avenue New Braunfels TX 78130 (830) 629-6462

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth: _____ Date completed: _____

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's or father's side**). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

			RELATIONSHIP	AGE AT DIAGNOSIS
BREAST AND OVARIAN CANCER				
Y	N	- Breast cancer before age 50		
Y	N	- Ovarian cancer		
Y	N	- Breast cancer in both breasts or multiple primary breast cancers		
Y	N	- Both breast & ovarian cancer (in an individual or family)		
Y	N	- Male breast cancer		
Y	N	- 2 or more breast or ovarian cancers (in an individual or a family)		
Y	N	- Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		
COLON AND UTERINE CANCER				
Y	N	- Uterine cancer before age 50		
Y	N	- Colorectal cancer before age 50		
Y	N	- Both uterine & colorectal cancer (in an individual or family)		
Y	N	- 2 or more uterine or colorectal cancers (in an individual or a family)		
Y	N	- Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)		
Y	N	- 10 or more colon polyps found in a lifetime		
MELANOMA				
Y	N	- 2 or more melanomas (in an individual or a family)		
Y	N	- Both melanoma and pancreatic cancer (in an individual or family)		

☒ Candidate for further risk assessment and/or genetic testing
☒ Information given to patient to review
☒ Follow up appointment scheduled Date: _____

☒ Patient offered genetic testing
☒ **Accepted** ☒ **Declined**

_____ _____
Patient's Signature Date

_____ _____
Health Care Provider's Signature Date

Mary E. Geldernick MD

Diplomat of The American Board of Obstetrics & Gynecology *Fellow of The American College of Obstetrics & Gynecology*

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard

___ CareCredit

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard HealthCare Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Signature

_____
Printed Name

_____
Date

505 North Union Avenue New Braunfels TX 78130 (830) 629-6462

Mary E. Geldernick, M.D.
505 N. Union
New Braunfels, TX 78130

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

I. Our Legal Responsibilities

This Privacy Notice is being provided to you as a requirement of a federal law known as the **Health Insurance Portability and Accountability Act ("HIPAA").** The Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information in some cases. Your **"protected health information"** means any written and oral health information about you, including demographic data that can be used to identify you.

We are required to follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on **April 14, 2003**, and will remain in effect until we replace it.

As permitted by law, we reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you at your next visit to our Practice. You may request a copy of our Notice at any time.

II. Examples of Uses and Disclosures of Protected Health Information:

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting health care operations.

A. Treatment. We may use or disclose your health information to a physician or other healthcare practitioner providing treatment to you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. We also may disclose medical information about you to people who may be involved in your medical care, which may include your family member, or other personal representatives.

B. Payment. We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give your healthcare information, regarding the treatment you received from us, to obtain payment or reimbursement for the care.

C. Healthcare Operations. We may use and disclose your health information in connection with healthcare operations. Healthcare operations include such activities as: quality assessment and improvement activities, training programs, medical reviews, and employee review activities, licensing and credentialing programs.

D. Uses of Information: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting area

when your physician is ready to see you, to contact you to remind you of your appointment.

E. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

F. To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

G. Persons Involved In Care: 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. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

H. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

I. Required by Law: We may use or disclose your health information when we are required to do so by law.

J. Abuse and Neglect: We may disclose your health information to public authorities as allowed by law to report abuse or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

K. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

III. Your Health Information Rights:

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

A. Right to Inspect and Copy: You have the right to inspect and copy your protected health information, with limited exceptions. (The request to review your records must be made in writing to the Privacy Officer. You may obtain a form to request access by using the contact information at the bottom of this Notice). We may deny your request under certain circumstances. If you request a copy of your information, we may

charge you a fee for the costs incurred by us in complying with your request. If you prefer, we may prepare a summary or an explanation of your health information for a fee.

B. Right to an Accounting Disclosure: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but **not before April 14, 2003**. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. Right to Request Restrictions: You have the right to request that we place additional restrictions on our use and disclosures of your protected health information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

D. Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

E. Right to Request an Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. If we deny your request for amendment, you have the right to file a statement of disagreement and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

F. 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.

IV. Questions and Complaints:

If you have any questions, would like additional information, or want to report a problem regarding the handling of your information, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by addressing a written complaint to the **Privacy Officer at** 505 NORTH UNION AVE. NEW BRAUNFELS., TEXAS 78130 You may also submit a written complaint to the Secretary of the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

We support the right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services