

New Patient Packet

Neurology

Edward J. Fox, MD, PhD
Multiple Sclerosis

Craig H. Couch, MD
Headache and Face Pain
General Neurology

Adam D. Horvit, MD
Neuromuscular Disorders
General Neurology

Terry S. Peery, DO
Epilepsy and Sleep Medicine
General Neurology

Elizabeth L. Peckham, DO
Movement Disorders
General Neurology

*Stephanie Agrella, MSN,
MSCN*
Multiple Sclerosis

Physical Therapy

Tina Warring, MPT

Clinical Research

Lori Mayer, DNP, MSCN
Director - Medical Research

Infusion Center

Janet S. Ellis, MSN

Electrodiagnostic Lab

Stephanie Tadlock, REEGT
Director - EEG Services

Administration

Vernon Christie
Practice Manager

Welcome to CTNC...the premier provider of neurological services in Central Texas. Enclosed in this packet is the information you need to create the necessary partnership between us. This packet is designed to assist you in maximizing the benefits of the services you receive from us. It includes a welcome letter, demographics, authorizations, our privacy policy and a "Health History Questionnaire" specific to the problem you are seeing us for.

We are better prepared for your visit when you **arrive 30 minutes early with your forms already filled out.** This will allow ample time for our staff to enter your medical history, insurance information and medications into our electronic medical record before your appointment. **If you do not arrive 30 minutes early with your forms already filled out then we may not be able to see you in a timely manner and, in some instances, may have to reschedule your appointment.**

When you come for your visit, please be sure to bring the following with you:

- Photo ID
- Completed patient registration packet (enclosed)
- Completed health questionnaire form (enclosed)
- Medical insurance information and cards
- Copies of pertinent medical records, labs, CT and MRI results
- Complete list of medications

Thank you for choosing CTNC.

Sincerely,

Vernon Christie

Vernon Christie
Practice Manager

PATIENT INFORMATION

(Section I)

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Email Address: _____
 Date Of Birth: _____ Sex: Male Female
 Social Security Number: _____
 Home Phone #: _____ Cell Phone #: _____
 Work Phone #: _____ Alt Phone #: _____
 Employer: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Drivers License#: _____ State Of Issue: _____

Marital Status:

Married
 Single
 Divorced
 Separated
 Widowed

Student:

Yes No

Retired:

Yes No

FINANCIAL RESPONSIBILITY

(Section II)

(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

CHECK HERE IF "SELF" & PROCEED TO SECTION 3

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Email Address: _____
 Date Of Birth: _____ Sex: Male Female
 Social Security Number: _____
 Home Phone #: _____ Cell Phone #: _____
 Work Phone #: _____ Alt Phone #: _____
 Employer: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Drivers License#: _____ State Of Issue: _____

Relationship:

Spouse
 Parent
 Legal Guardian
 Other (Specify)

EMERGENCY CONTACT

(Section III)

Contact Name: _____
 Relationship: _____
 Contact Phone #(s): _____

FOR OFFICE USE ONLY:

Appointment Date: _____ Demos Rec'vd On: _____ Insurance Setup Patient History Entered

PHARMACY INFORMATION (Please provide complete address)

(Section IV)

Name Of Pharmacy: _____

Address, City, Zip Code: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

PRIMARY INSURANCE INFORMATION

(GIVE CARD TO RECEPTIONIST UPON ARRIVAL)

(Section V)

Insurance Company: _____

Claims Address: _____

City: _____

State: _____

Zip: _____

Phone # for Providers/Eligibility & Benefits: _____

Member Number: _____

Group Number: _____

Insured's Full Name: _____

Insured's Social Security No.: _____

Insured's Date Of Birth: _____

Relationship to Insured:

 Spouse Parent Legal Guardian Other (Specify)**SECONDARY INSURANCE INFORMATION**

(GIVE CARD TO RECEPTIONIST UPON ARRIVAL)

(Section VI)

Insurance Company: _____

Claims Address: _____

City: _____

State: _____

Zip: _____

Phone # for Providers/Eligibility & Benefits: _____

Member Number: _____

Group Number: _____

Insured's Full Name: _____

Insured's Social Security No.: _____

Insured's Date Of Birth: _____

Relationship to Insured:

 Spouse Parent Legal Guardian Other (Specify)**HOW DID YOU HEAR ABOUT US?**

(Section VII)

 Referred by Physician - Physician's Name: _____

Phone: _____

Fax: _____

 Internet Website or Search Engine – Which site did you initially find us on? _____ Newspaper/Magazine Article Or Ad – Which publication? _____ Insurance Plan (Check here if you found us thru your insurance plan's website or in their provider directory.) Friend or Family Member: _____ Other – Please describe: _____

PATIENT NAME: _____

Treatment Authorization

(Check and sign the applicable paragraph)

- I authorize Central Texas Neurology Consultants, PA to examine, diagnose and treat me. I authorize and give Central Texas Neurology Consultants, PA consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analysis and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

SIGNATURE OF PATIENT

DATE

- I hereby authorize Central Texas Neurology Consultants, PA to examine and treat _____
(name of patient)

I authorize and give Central Texas Neurology Consultants, PA my consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

SIGNATURE OF PATIENT or REPRESENTATIVE

DATE

Acknowledgement of No Show & Late Cancellation Policy

Patients who fail to show up for their scheduled appointments or fail to give 24 hours' notice when canceling or rescheduling their appointments place an extra burden on the staff of CTNC. Furthermore, since the appointment goes unfilled, this represents either a delay to see another patient or a financial burden to CTNC. Therefore, CTNC has implemented the following policy:

- A **\$25 charge** will be assessed for “no-showing” or failing to give 24-hour notice of the need to cancel **routine follow-up appointments**
- A **\$100 charge** will be assessed for “no-showing” or failing to give 24-hour notice of the need to cancel **NEW PATIENT appointments and scheduled PROCEDURES**, including EMG, EEG and Home Sleep Testing

These charges are not billable to your insurance company and will ultimately be the responsibility of the patient. All no-show and late cancellation fees will need to be paid before your next appointment with the physician. If a patient has 3 no-show or late cancellations, they may be dismissed from the practice.

SIGNATURE OF PATIENT or REPRESENTATIVE

DATE

Prescription Benefits and Medication History

I give consent to CTNC to download my prescription benefits and medication history information from Surescripts pharmacy clearinghouse.

SIGNATURE OF PATIENT or REPRESENTATIVE

DATE

Authorization for Release of Information

I hereby authorize Central Texas Neurology Consultants, PA to release any information necessary to my insurance company (ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

SIGNATURE OF PATIENT or REPRESENTATIVE

DATE

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I acknowledge that I have received a copy of CTNC's "Notices of Protected Health Information Practices".

SIGNATURE OF PATIENT or REPRESENTATIVE

DATE

Authorized Contacts

Many times family members will call and ask or give medically related information about the patient. So we may properly protect your privacy, please indicate yes, no, or n/a if you would like for us to share or discuss your private medical information with any of the following relatives/groups of people:

Yes	No	N/A	Name of Individual(s):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult Child(ren): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other(s): _____

I do not wish my information to be disclosed to any person.

Initial and Date: _____

Miscellaneous Fees

- **Filling Out Disability Forms: \$25**
Note: The patient may also need to schedule an appointment with their physician for an exam.
- **Medical Records: \$25 for the first 20 pages and \$0.50 for each additional page.**
Note: Requests for recent office visit notes will be sent to other physicians for no charge as a courtesy but requests for complete charts or extensive records will be charged at the rates listed above. The patient will be responsible for any charges incurred for their medical records.
- **Returned Check Fee: \$35**

Payment Policy

I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Central Texas Neurology Consultants, PA files claims for Medicare assignment and only the commercial care plans with which we are contracted. Claims will not be filed with other insurance carriers.

NAME of Insured / Responsible Party

Signature of Insured / Responsible Party

Date

Legal Irrevocable Assignment Of Benefits And Release Of Medical And Summary Plan Documents

In considering the amount of expenses to be incurred, I _____, the undersigned, have insurance and/or employee health care benefits coverage with _____ (insurance co. information), and hereby irrevocably assign and convey directly to the treating physicians at Central Texas Neurology Consultants, P.A. (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider/practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. **All payments will be made to provider and practice at: Central Texas Neurology Consultants, P.A., 16040 Park Valley Drive, Building B, Suite 100, Round Rock, TX 78681.**

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and practice in any attempts by such provider and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider and practice against any insurers and/or employee health care plan in my name but at such provider and practice's expense.

This lifetime assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

NAME of Insured / Responsible Party

Signature of Insured / Responsible Party

Date

Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Vernon Christie, Privacy Officer, Central Texas Neurology Clinic, P.A.,
16040 Park Valley Dr., Bldg. B, Suite 100, Round Rock, Texas 78681

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (UHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice — including, but not limited to, our doctors and nurses — may use or disclose your IIHI, in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care provider for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your HHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births and deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - reporting reactions to drugs or problems with products or devices
 - notifying individuals if a product or device they may be using has been recalled
 - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena or similar legal process
 - To identify/locate a suspect, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. **Military.** Our practice may disclose your ITHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of State, or to conduct investigations.
9. **Inmates.** Our practice may disclose your JIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice & communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to our Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear and concise fashion:
 - a) the information you wish restricted;
 - b) whether you are requesting to limit our practice's use, disclosure or both; and
 - c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Officer in order to inspect and/or obtain a copy of your JIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your III-II for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our Privacy Officer. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer, We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

**Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018**

Si necesita ayuda para presentar una queja, llame al:

1-800-201-9353

Para obtener más información, visite nuestro sitio web en

www.tmb.state.tx.us