Thank you for your interest in The Prosthetic Foundation (TPF). We want to assure you that your prosthetic needs are important to us and that we do our best to process and approve as many applications as we possibly can.

Our mission is to *provide support and access for uninsured or under-insured amputees to obtain quality prosthetics with comprehensive aftercare, and to generate public awareness for these individuals.*

What does this mean for an amputee?

It means that we can help them to get a prosthesis, if they cannot afford it. Some amputees do not have health insurance, or they rely on Medicaid. The problem with Medicaid in Texas is that it does **not** cover prosthetics for adults. For other amputees fortunate enough to have private health insurance, spending caps and high deductibles or co-insurance costs prevent them from being able to afford their prosthetic devices. For these reasons, too many amputees remain confined to a wheelchair.

What are the qualifications?

The qualifying circumstances for an amputee to receive an application for our program are: (1) He/she must be a U.S. citizen or non-citizen ***lawfully*** in the U.S.; and (2) He/she must reside in the State of Texas. If the amputee qualifies under **both** conditions, they will receive an application for assistance.

The application requires a lot of personal and medical information, as well as evidence of the information being provided. All the information collected helps us to make an informed decision about the applicant's eligibility and merit.

What is a financial hardship?

Financial hardship is a situation in which a serious change occurs in financial circumstances such as losing a job or encountering a serious medical condition with high out-of-pocket medical costs. Our decision on hardship relates to the overall finances and reasonable request made by the applicant. The documents and information we request helps to demonstrate the applicant's financial need for assistance.

Letters of Recommendation

Along with financial documents, we also request a letter of recommendation from two of the applicant's health care providers; (1) His/her primary care doctor (PCP) ***or*** the surgeon who performed the amputation; **and** (2) His/her prosthetist.

A signed letter of recommendation from the PCP or surgeon should state that the applicant is a good candidate and how he/she will benefit from a prosthesis to accomplish activities of daily living. Such reasons may be that the applicant is consistently medically compliant, has the desire to return to work, wants to be able to participate in social activities with family and friends, wants to be active in their community again, or the like.

The signed letter of recommendation from the prosthetist must include the current and expected functional level for the specific device that is being proposed. And, it must also validate the functional level by describing the patient's expected activities of daily living to support the proposed K-Level.

POWER OF PROSTHETICS PROGRAM

All the information collected helps us to make an informed decision about the applicant's eligibility and merit so please be sure to complete all portions of the application and submit all the requested documents. Please note that the completion of these forms does not guarantee approval. Also note that all payments are made directly to the prosthetist, we will not reimburse nor pay the applicant directly.

Make sure to include the following items with this application:

- ☐ A copy of your valid Texas driver's license or state-issued ID that includes your home address
- ☐ A copy of your social security card
- ☐ The first two pages of your federal income tax return, for the past two years ***or*** your SSI award letter ***or*** the last four check stubs for yourself and your spouse
- ☐ Receipt for your rent or mortgage, or a letter signed by your landlord that includes monthly payment amount and whether it includes utilities
- ☐ Current receipts of reasonable monthly expenses like electricity, water, property taxes, car loan, etc.
- ☐ A signed Authorization for Release of Medical Information for each of the following providers; 1) Your primary care provider ***or*** the surgeon who performed the amputation; and 2) Your prosthetist
- ☐ Signed TPF Consent to Photograph, Record, Publish or Broadcast

Please verify that you have completed, signed and enclosed all documents to avoid any processing delays. Keep pages 11-14 of this application for your records and mail the rest of the pages and documents to:

The Prosthetic Foundation
5047 Sherri Ann Road
San Antonio, TX 78233

You may fax them to (210) 828-0590, if you prefer

If you have any questions, please send us an email at elanderos@theprostheticfoundation.org or call us at (210) 237-4328.

FINANCIAL INFORMATION SHEET

Today's date: _____

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

In order to determine if you qualify for our program, you ***must complete*** this form in its entirety.

Total gross monthly income: $ _____

Sources of income: _____

Number of people supported by this monthly income: _____

Monthly Rent or Mortgage payment amount: _____

Amount of monthly payments made to your doctor and/or hospital: _____

Monthly prescription/ medication costs: _____

Do you have any insurance or other party that will assist you in paying for your medical expenses? If so, please indicate below:

Insurance/Name:_____ Policy/ID number: _____

Insurance Company Address or Phone #: _____

Please read the following statement, and sign below:

To the best of my knowledge, the information indicated above is true and correct. I give The Prosthetic Foundation permission to verify the information above and permit The Prosthetic Foundation to obtain a consumer report pursuant to Section 604(a) (2) of the Fair Credit Reporting Act to verify all financial information presented in this application.

_____ **X** _____ _____

(Print Name) (Signature) (Date)

For Office Use Only:	Effective Date:	to	Initials: _____
Annual Income:	# in Household:		Sliding Scale Level: _____

APPLICATION – Power of Prosthetics Grant

PLEASE FILL IN ALL INFORMATION

Email Address: _____

Applicant's Name: _____ Date of Birth: _____
Last First Middle Initial (mm/dd/yyyy)

Address: _____
(No PO Box numbers please)

City: _____ State: _____ Zip: _____ Phone: (____) _____

Are you a citizen of the United States or a non-citizen ***lawfully*** in the United States? [ ] Yes [ ] No

Gender: [ ] Male [ ] Female Social Security Number: _____

Age Demographics:
[ ] 18 and under
[ ] 18-30
[ ] 30-40
[ ] 40-50
[ ] 50-65
[ ] 65 and over

Marital Status:
[ ] Married
[ ] Divorced
[ ] Single
[ ] Separated
[ ] Widowed

Education Level:
[ ] Some High School
[ ] High School or Equivalent (GED)
[ ] Attended Some College
[ ] College Degree
[ ] Post Graduate Degree

Racial or Ethnic Demographics:
[ ] Caucasian
[ ] Hispanic
[ ] Black (African-American)
[ ] Asian
[ ] American Indian or Alaska Native
[ ] Native Hawaiian or Other Pacific Islander
[ ] Other: _____

Income Demographics:
[ ] $20,000 and under
[ ] $20,001 - $40,000
[ ] $40,001 - $60,000
[ ] $60,001 and above

Employer: _____ Occupation: _____

Address: _____

Length of time working for current employer: _____

Spouse (if applicable): Name: _____
Last First Middle Initial

Driver's License #: _____ Date of Birth: _____
(mes/fecha/ano)

Spouse's Employer: _____

Address: _____

Length of time working for current employer: _____

Names of dependents: _____

_____

Closest family member not living with you (include address):

Address: _____ Phone: (_____)_____

Applicant's annual income: _____ Combined household income: _____

Please describe the applicant's present condition:

_____

_____

_____

_____

_____

Please describe any medical conditions that are related to the applicant's present condition:

_____

_____

_____

_____

_____

_____ Initial Here

Please describe the reason or cause for amputation and include whether it's a **below-** or **above-the-knee** amputation and which leg it's on, **left** or **right** side, or if it's **bilateral**:

Amputation date and hospital where the procedure was performed:

Please describe how you would like The Prosthetic Foundation to help you:

Please describe your present financial situation and why you feel that you should be considered for assistance:

Please describe what assistance, if any, is available from family or friends:

If you are selected for a grant, can you contribute time and/or finances? [ ] Yes [ ] No

If so, how much time/finances? _____

_____ Initial Here

Print Name: _____

We require letters of recommendation from your Primary Care Physician (PCP) or the surgeon who performed your amputation, and from your prosthetist. Please provide us with their names:

- Primary Care Physician: _____

- Prosthetist: _____
  (***Your Prosthetist is the company that is fitting you and making your prosthetic leg***)

I agree to waive any and all legal rights, which may arise as a result of charitable treatment I may receive from The Prosthetic Foundation patient care grant.

_____ _____
Signature Date

I attest that all information provided above in this application is accurate to the best of my knowledge. I understand that any false statement or misrepresentations will make me ineligible for consideration for a patient care grant, which payments will only be made to clinics and vendors on behalf of the amputee.

_____ _____
Signature Date

Authorization for Release of Medical Information

HIPAA COMPLIANT RELEASE

Patient Name: _____ Date of Birth: _____

Release Information from: *(Please complete this section with your **primary care doctor or surgeon's** information)*

Hospital/Physician: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I hereby authorize and request the exchange of information between The Prosthetic Foundation and the above-named individual/organization. The following information is requested to be shared:

☐ **All**	☒ Counselor Reports	☐ Test Results
☒ Office Notes	☒ Intake Assessment	☒ Treatment Plan
☐ Psych/Social/Emotional Evaluation	☐ Medications	☒ Discharge Summary
☐ Immunizations	☒ Summaries	

Date range of records to release (check one): Only documents from _____ to _____ ☐ All dates

Reason for Request: _____

Form of Disclosure (check all allowed) ☐ Written ☐ Verbal ☐ Electronic

- Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

NOTE: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information complied in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

- I understand I may revoke this authorization at any time by notifying THE PROSTHETIC FOUNDATION in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand I have a right to request and receive a **Notice of Privacy Practices** for THE PROSTHETIC FOUNDATION.
- All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____
- I hereby authorized the following; (please initial if applicable)

Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

_____ _____ _____

Signature of Patient or Patient's Representative | Printed Name | Relationship

Witness Signature/Printed Name: _____ Date: _____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Authorization for Release of Medical Information

HIPAA COMPLIANT RELEASE

Patient Name: _____ Date of Birth: _____

Release Information from: *(Please complete this section with your **prosthetist's** information)*

Hospital/Physician: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I hereby authorize and request the exchange of information between The Prosthetic Foundation and the above-named individual/organization. The following information is requested to be shared:

☐ **All**	☒ Counselor Reports	☐ Test Results
☒ Office Notes	☒ Intake Assessment	☒ Treatment Plan
☐ Psych/Social/Emotional Evaluation	☐ Medications	☒ Discharge Summary
☐ Immunizations	☒ Summaries	

Date range of records to release (check one): Only documents from _____ to _____ ☐ All dates

Reason for Request: _____

Form of Disclosure (check all allowed) ☐ Written ☐ Verbal ☐ Electronic

- Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

NOTE: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information complied in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

- I understand I may revoke this authorization at any time by notifying THE PROSTHETIC FOUNDATION in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand I have a right to request and receive a **Notice of Privacy Practices** for THE PROSTHETIC FOUNDATION.
- All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____
- I hereby authorized the following; (please initial if applicable)

Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

_____ _____ _____

Signature of Patient or Patient's Representative | Printed Name | Relationship

Witness Signature/Printed Name: _____ Date: _____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Consent to Photograph, Record, Publish or Broadcast

Name of person to be photographed or recorded: _____

Relationship to The Prosthetic Foundation: _____. The undersigned does hereby authorize The Prosthetic Foundation and/or the attending physicians or their designees to:

Please Initial Appropriate Box (es):

☐ GENERAL USE: Take and reproduce photographs, motion pictures, video and/or audio tapes, slides or other media of the above-named person in connection with the diagnosis, care and treatment, or functional capacity of the above-named facility. Use of such materials and the person's name in connection with any publication or broadcast (including, but not limited to, newspapers, television and/or radio, books, brochures, magazines and motion pictures) is not limited to scientific or educational purposes and may be used in such manner and in such times and in such places as The Prosthetic Foundation shall determine, without restriction on its sole discretion.

☐ SCIENTIFIC AND EDUCATION PURPOSES ONLY: Take and reproduce photographs, motion pictures, video and/or audio tapes, slides or other media of the above-named person in connection with the diagnosis, care and treatment, or functional capacity of the above-named facility. Use of such materials and the person's name in connection with any publication or broadcast (including, but not limited to, newspapers, television and/or radio, books, brochures, magazines and motion pictures) is limited to scientific or educational purposes only.

Limitations, if any:

_____

I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, publication, or broadcast of the above regardless of whether such exhibition, publication, or broadcast is philanthropically, commercially, institutionally or privately sponsored and regardless of whether a fee for admission or rental is charged.

I release The Prosthetic Foundation and its physicians, employees and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective unless revoked in writing.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent or Legal Guardian (if patient is under 18) Telephone #, including area code

_____

Street Address City/State Zip Code

_____ _____

Witness' Signature Date

Please keep the following pages for your records

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

THIS NOTICE IS A REVISION AND BECAME EFFECTIVE November 14, 2014

If you have any questions about this notice, please contact
The Prosthetic Foundation
5047 Sherri Ann Rd
San Antonio, Texas 78233
Phone: 210-237-4400, Fax: 210-828-0590

PROVIDER/CLINIC OBLIGATIONS:
We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of our notice that is currently in effect
- In Texas, inform you that we disclose your Protected Health Information (PHI) electronically
- Notify you of a breach of protected information as required by federal and state law

PROTECTED HEALTH INFORMATION:
Protected health information is defined by HIPAA as individually identifiable health information; it can be verbal, written or electronic.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
The following describes the ways we may use and disclose Health Information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval

process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye, tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, location of the person who committed the crime.

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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. The release, if necessary, would be for the institution: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) to provide the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify and your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and obtain a copy of Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to The Prosthetic Foundation 5047 Sherri Ann Rd., San Antonio, Texas 78233. In Texas, we have up to 15 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record),

you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to The Prosthetic Foundation 5047 Sherri Ann Rd., San Antonio, Texas 78233.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to The Prosthetic Foundation 5047 Sherri Ann Rd., San Antonio, Texas 78233.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to The Prosthetic Foundation 5047 Sherri Ann Rd., San Antonio, Texas 78233. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to The Prosthetic Foundation 5047 Sherri Ann Rd., San Antonio, Texas 78233. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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. You may obtain a copy of this notice at our web site, www.pvasatx.com. To obtain a paper copy of this notice, please see Receptionist.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page of the notice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer at The Prosthetic Foundation. All complaints must be made in writing. **You will not be penalized for filing a complaint**.