THE WOODLANDS
LOW VISION CLINIC

Patient Registration

Please present your medical or vision insurance card(s) & photo id.

Full Name: ____

Date of Birth: ___________ Last 4 Digits of Social Security #: ___________

Phone Number: ___________________ Fax#: ____________________

Email Address: ____

Gender: ☐ Male ☐ Female Other: ________________

Preferred Language: ☐ English ☐ Spanish Other: ______________

Street Address: ____

City/State/Zip Code: _______________________________________

How did you hear about us? __________________________________

<u>Emergency Contact:</u>

Name: ____

Phone Number: ______________ Relationship: ___________________

<u>Insurance Information (Medical or Vision)</u>

Insurance Company #1: ______________ Phone #:______________

Policy #: __________________ Group #: __________________

Primary Insured's Name: ___________________________________

Date of Birth: ____________________ Relationship: _____________

Ins. Company #2 (if used): _____________ Phone #:______________

Policy #: __________________ Group #: __________________

Primary Insured's Name: ___________________________________

Date of Birth: ____________________ Relationship: _____________

Financial Agreement, Release of Medical Information and Notice of Privacy Practices

If this document is being signed by a legally authorized representative:

____

Printed name of legally authorized representative

____

Legally authorized representative's relationship to Individual/Patient

◊ I hereby authorize the payment of medical benefits to Nayfach Optometry PLLC DBA The Woodlands Low Vision Clinic for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I permit a copy of this authorization to be used in place of the original. I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.

_______ **(Please initial)**

◊ In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare, or other third-party payer benefits for medical or health care services otherwise payable to me to The Woodlands Low Vision Clinic. I also authorize direct payments to be made by Medicare and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to The Woodlands Low Vision Clinic. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare or Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by The Woodlands Low Vision Clinic.

_______ **(Please initial)**

◊ I voluntarily consent to receive medical and health care services provided by The Woodlands Low Vision Clinic providers, employees and other associates as my providers deem necessary. I understand that such services may include diagnostic procedures, electronic prescription exchange, examinations, and treatment. I understand that this consent to treatment will be valid and remain in effect as long as I

am a patient of The Woodlands Low Vision Clinic unless revoked by me in writing with such written notice provided to each clinic attended by me.

_______ **(Please initial)**

◊ Your protected health information pertains to your diagnosis and/or treatment at The Woodlands Low Vision Clinic, including but not limited to information concerning mental illness, use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information. Our Notice of Privacy Practices provides information about how The Woodlands Low Vision Clinic may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. I understand The Woodlands Low Vision Clinic cannot be responsible for use or re-disclosure of information by third parties.

_______ **(Please initial)**

Low Vision Exam Cancellation Policy:

◊ In consideration for the substantial time spent on appointments in our clinic (2-4 hours), we have a cancellation fee of $50 for any low vision appointment not cancelled within 24 hours before the exam start time. In addition, we reserve the right to not reschedule a patient who fails to present for his or her exam.

_______ **(Please initial)**

1. *I authorize Nayfach Optometry PLLC to treat me and use my personal health information for healthcare operations.*
2. *I agree to each of the terms set forth under the previous section titled "Financial Agreement, Release of Medical Information and Notice of Privacy Practices".*
3. *I received a Notice of Privacy Practices from The Woodlands Low Vision Clinic which contains a description of the uses and disclosures of my health information, my rights regarding my health information and The Woodlands Low Vision Clinic's legal duties concerning such.*
4. *I hereby authorize Nayfach Optometry PLLC to release any medical information necessary to complete and process my insurance claims.*

X ____

Patient's Signature **Date**

Note: If patient is a Minor, must have a responsible party sign

Staff Use Only

I attempted to obtain the patient's acknowledgement for receipt of The Woodlands Low Vision Clinic Notice of Privacy Practices but was unable to do so as documented below:

Staff name:____

Signature:____________________________ Date:________________

May we phone, email, or send a text to you to confirm appointments?

☐ YES or ☐ NO

May we leave a message on your answering machine at home or on your cell phone?

☐ YES or ☐ NO

Medical History Questionnaire

Reason for today's exam? ____

____

____

Do you recall your last eye exam ? ☐ Yes ☐ No

If yes, please provide details here: ____________________________________

Eye doctor: ____________________________________ ☐ OD ☐ MD

Office Contact Information:____

When are you scheduled for your next exam? ______________________________

List of Medications (oral, injected, or drops) being taken & for what condition:

1.	5.
2.	6.
3.	7.
4.	8.

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medication(s): ___________________________________

Do you have any other allergies? ☐ Yes ☐ No

Please list any diseases of your eyes and when you were diagnosed, if any.
____
____

Please note any systemic diseases and when you were diagnosed, if any.
____
____

Please list any surgeries (of the eye or otherwise):

1. ____ Date: ____________
2. ____ Date: ____________
3. ____ Date: ____________
4. ____ Date: ____________

Do you wear: ☐ glasses ☐ contact lenses ☐ none

Have you ever worn contacts? ☐ Yes ☐ No

Do you wear prescription sunglasses: ☐ Yes ☐ No

Social History Questionnaire

(responses are **optional** and not all questions will apply to every patient)

Marital Status?

_____Single _____Married _____Partner _____Divorced _____Widowed

Do you live alone or with others?

_____Alone _____With others

Number of children? _______

Are you a U.S. Veteran? ____Yes ____No

What is your current living environment (house, assisted-living etc.), and do you need to use stairs? ____

____

History of falling (if any) and dates: ____________________________________

Describe any tasks you can no longer perform due to your vision impairment?

____

List any low-vision devices you are using: ______________________________

____

List any low vision exams you had in the past: ________________________________

____

Are you currently employed?____Yes _____No _____Student ____Retired

What is / was the nature of your work? ___________________________________

Education Level?_____Student ___High school __Bachelor ____Post grad

Are you legally blind in one or both eyes? ______Yes ______No

Do you have transportation difficulties? _____Yes ______No

What is your general stress level? ___Low _____Medium ______High

Alcohol Intake? ______None ____Occasional ______Moderate ____Often

Tobacco Smoking Status? _______Never _____Former _____Current

Family History

	Family Member(s)
Alcohol abuse	______________________________
Anxiety disorder	______________________________
ADD/ADHD	______________________________
Bipolar disorder	______________________________
Blindness	______________________________
Dementia	______________________________
Depressive disorder	______________________________
Diabetes mellitus	______________________________
Disease of the liver	______________________________
Epilepsy	______________________________
Glaucoma	______________________________
Headache	______________________________
Hearing loss	______________________________
Heart disease	______________________________
Hypertensive disorder	______________________________
Kidney disease	______________________________
Mental disorder	______________________________
Migraine	______________________________
Obesity	______________________________
Substance abuse	______________________________
Other	______________________________

Personal Medical History

	If issue is present, please describe:
Diabetic eye disease	______________________________
Eye trauma	______________________________
Glaucoma	______________________________
Macular degeneration	______________________________
Head injury/concussion	______________________________
Anxiety disorder	______________________________
Asthma	______________________________
Brain injury	______________________________
Cancer	______________________________
Depression	______________________________
Obesity	______________________________
Hearing loss	______________________________
Heart disease	______________________________
Mental disorder	______________________________
Psychiatric condition	______________________________
Substance abuse	______________________________
Visual hallucinations	______________________________
Other	______________________________

Neurological

Headaches _____Yes

Migraines _____Yes

Seizures _____Yes

Cardiovascular

Diabetes _____Yes

Chest pain _____Yes

High BP _____Yes

Vascular disease _____Yes

High cholesterol _____Yes

Ocular / Vision

Loss of vision	_____Yes	Lazy eye	_____Yes
Blurred vision	_____Yes	Drooping eyelid	_____Yes
Flashes of Light	_____Yes	Prominent eyes	_____Yes
Floaters	_____Yes	Eye infections	_____Yes
Distorted vision	_____Yes	Gritty / sandy	_____Yes
Fluctuating vision	_____Yes	Mucous discharge	_____Yes
Glare/light sensitivity	_____Yes	Redness	_____Yes
Contrast Loss	_____Yes	Burning	_____Yes
Double vision	_____Yes	Pain or soreness	_____Yes
Fatigue with reading	_____Yes	Tearing / watering	_____Yes
Eye injury	_____Yes	Dryness	_____Yes

Authorization To REQUEST Health Information

1441 Woodstead Ct. Ste 110
The Woodlands, TX 77380
(281) 944-EYES (3937)
clinic@woodlandslowvision.com

Patient Information

Name: ____
Date of Birth: ____
Address: ____
City: ____________________State: _________ Zip Code: ____________________
Telephone: ____
Email: ____

Information To Be Requested

I authorize The Woodlands Low Vision Clinic to **RECEIVE** records ***FROM:***

Physician Name (required): _________________________________
Address: ____
City: ____________________State: _________ Zip Code: __________
Telephone: ____
Fax: ____
Email: ____

Method of Delivery:

- ☐ Any of the following: Mail, Fax, Pick-up, Secure Email, Verbal
- ☐ **Specify:** _________________

Effective Time Period for Authorization (optional):
The authorization is valid until the earlier of: the authorization is withdrawn, the age of majority, the patient's death, or the following specified date (optional): ___________

Information REQUESTED:

- ☐ All health records from the past 12 months OR
- ☐ Records from _________ to __________ OR
- ☐ All available records OR
- ☐ Other specified medical information (as indicated here):

PURPOSE OF DISCLOSURE:

- ☐ Continued medical care
- ☐ Patient request
- ☐ S.S. Disability Determination
- ☐ Other:__________________________

Unless otherwise specified, records may exclude HIV testing, mental health records, genetic information, and chemical dependency testing.

RECIPIENT of Information

I am authorizing transmission of this information ***to:***
Entity: The Woodlands Low Vision Clinic
Address: 1441 Woodstead Ct #110
City: The Woodlands State: TX Zip Code: 77380
Phone/Fax: **Secure Fax (281) 721-4433**
Email: clinic@woodlandslowvision.com

Consent and Signature

By signing below, I understand and agree to the following:

1. *I authorize the release of protected health information as indicated above to the approved listed party.*
2. *I may revoke this authorization at any time by sending a written revocation. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.*
3. *Any treatment, payment, or eligibility for services or benefits will not be affected if I do not sign this authorization.*
4. *Any information disclosed by this authorization to any person/organization not a healthcare provider, business associate of a healthcare provider or health plan covered by federal and state privacy regulations could be redisclosed by the recipient and no longer protected by those regulations.*
5. *I am entitled to receive a copy of this authorization.*
6. *I understand that requests for copies of records are subject to fees in accordance with federal and Texas regulations.*

____

Signature of Patient/Guardian/Legal Representative **Date**

____

Printed Name **Relationship, if not patient**

Authorization To RELEASE Health Information

1441 Woodstead Ct. Ste 110
The Woodlands, TX 77380
(281) 944-EYES (3937)
clinic@woodlandslowvision.com

Patient Information

Name: ____
Date of Birth: ____
Address: ____
City: ___________________State: ________ Zip Code: _________
Telephone: ____
Email: ____

Information To Be RELEASED

I authorize The Woodlands Low Vision Clinic to **SEND** records ***TO:***

Physician Name: ____
Address: ____
City: ___________________State: ________ Zip Code: _________
Telephone: ____
Fax: ____
Email: ____

Method of Delivery:

- ☐ Any of the following: Mail, Fax, Pick-up, Secure Email, Verbal
- ☐ **Specify:** ________________

Effective Time Period for Authorization (optional):
The authorization is valid until the earlier of: the authorization is withdrawn, the age of majority, the patient's death, or the following specified date (optional): __________

Information RELEASED:

- ☐ All health records from the past 12 months OR
- ☐ Records from ________ to _________ OR
- ☐ All available records OR
- ☐ Other specified medical information (as indicated here):

Purpose of Disclosure:

- ☐ Continued medical care
- ☐ Patient request
- ☐ S.S. Disability Determination
- ☐ Other:_________________________

Unless otherwise specified, records may exclude HIV testing, mental health records, genetic information, and chemical dependency testing.

SENDER of Information

I am authorizing transmission of this information ***from:***
Entity: The Woodlands Low Vision Clinic
Address: 1441 Woodstead Ct #110
City: The Woodlands State: TX Zip Code: 77380
Phone/Fax: **Secure Fax (281) 721-4433**
Email: clinic@woodlandslowvision.com

Consent and Signature

By signing below, I understand and agree to the following:

1. *I authorize the release of protected health information as indicated above to the approved listed party.*
2. *I may revoke this authorization at any time by sending a written revocation. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.*
3. *Any treatment, payment, or eligibility for services or benefits will not be affected if I do not sign this authorization.*
4. *Any information disclosed by this authorization to any person/organization not a healthcare provider, business associate of a healthcare provider or health plan covered by federal and state privacy regulations could be redisclosed by the recipient and no longer protected by those regulations.*
5. *I am entitled to receive a copy of this authorization.*
6. *I understand that requests for copies of records are subject to fees in accordance with federal and Texas regulations.*

____

Signature of Patient/Guardian/Legal Representative **Date**

____

Printed Name **Relationship, if not patient**

Texas Sales and Use Tax Exemption Certification

This certificate does not require a number to be valid.

Name of purchaser, firm or agency	
Address *(Street & number, P.O. Box or Route number)*	Phone *(Area code and number)*
City, State, ZIP code	

I, the purchaser named above, claim an exemption from payment of sales and use taxes (for the purchase of taxable items described below or on the attached order or invoice) from:

Seller: ______________________________

Street address: ______________________ City, State, ZIP code: ______________________

Description of items to be purchased or on the attached order or invoice:

____

Purchaser claims this exemption for the following reason:

____

I understand that I will be liable for payment of all state and local sales or use taxes which may become due for failure to comply with the provisions of the Tax Code and/or all applicable law.

I understand that it is a criminal offense to give an exemption certificate to the seller for taxable items that I know, at the time of purchase, will be used in a manner other than that expressed in this certificate, and depending on the amount of tax evaded, the offense may range from a Class C misdemeanor to a felony of the second degree.

sign here ▸ Purchaser	Title	Date

NOTE: This certificate cannot be issued for the purchase, lease, or rental of a motor vehicle.

THIS CERTIFICATE DOES NOT REQUIRE A NUMBER TO BE VALID.

Sales and Use Tax "Exemption Numbers" or "Tax Exempt" Numbers do not exist.

This certificate should be furnished to the supplier.
Do not send the completed certificate to the Comptroller of Public Accounts.

Notice of Privacy Practices

IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY

Privacy Officer: Joseph Nayfach-Battilana
jnayfach@woodlandslowvision.com
Ph (281) 944-3937

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

Treatment, Payment and Healthcare Operations

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voice mails or emails; calling your name out in a reception room environment; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails reminding you it is time for continued care; at your request, we can provide you with a copy of your medical records via email transmission.

At your request, we may not disclose health care information for services you paid for out of pocket. This only applies to those encounters related to the care you want restricted.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payors in order to insure payment for services rendered to you; sending notices of payment due on your account to the person designated as responsible party or head of household on your account with fee explanations that could include procedures performed and for what diagnosis: collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits; providing information regarding your vision status to the Department of Public Safety, a school nurse, or agency qualifying for disability status

Uses and Disclosures for Other Reasons Not Needing Permission

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to a workman's compensation claim
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures
- Disclosure of information needed in completing forms from a schools related vision screening, information to the Department of Public Safety, information related to certification for occupational or recreational licenses such as pilots license.
- Disclosures to business associates who perform health care operations for Nayfach Optometry PLLC and who commit to respect the privacy of your information. We also require any business associate to require any sub-contractor to comply with our privacy policies.
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

Uses or Disclosures to Patient Representatives

It is the policy of Nayfach Optometry PLLC for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Nayfach Optometry PLLC staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Nayfach Optometry PLLC staff and doctors will also infer that if you allow another person in an examination room, treatment room, dispensary, or any business area within the office with you while testing is performed or discussions held about your vision or health care or your account that you consent to the presence of that individual.

Other Uses and Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written Authorization for Release of Identifying Health Information. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Nayfach Optometry PLLC or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your personal health information. You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request.

Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While

we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

Health care information you request copies of may be delivered to you in electronic format. The e-formats Nayfach Optometry PLLC has approved as secure and protects the integrity of your health care information include secure email, an authorized Electronic Health Information system and media supplied by Nayfach Optometry PLLC.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Nayfach Optometry PLLC. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $25.00 for the first 20 pages and $.50 per page thereafter, plus the actual cost of shipping per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

Breach Notification Policy

In the event of a reportable breach of patient information, Nayfach Optometry PLLC agrees to abide by the breach notification requirements as established by the HIPAA Breach Notification Rule. If a breach occurs, Nayfach Optometry PLLC will consult with a HIPAA attorney and take all necessary steps to remain in compliance with this rule including notification of individuals, Business Associates, the Secretary of Health and Human Services and prominent media outlets.

Whistleblower Protection Rule

Nayfach Optometry PLLC will take no action against any individual who provides information to the Office of Civil Rights, Office of the Inspector General or individual state Attorney General's Office regarding concerns related to the privacy and security procedures or actions at Nayfach Optometry PLLC.

Changing Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to substantially change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice to our website.

Complaints

If you think that anyone at Nayfach Optometry PLLC has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing. If we cannot resolve your concern at that level, you may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights or the Texas Attorney General's Office. We will not retaliate against you if you make such a complaint.