

“A Timeless Welcome”

We would like to take this opportunity to welcome you and to thank you for choosing Timeless Plastic Surgery. Having plastic surgery is a big decision that deserves thoughtful consideration. You made an important first decision when you scheduled a consultation with Timeless! We wish to make your visits more informative and your surgical experience pleasant and rewarding.

We are dedicated to excellence in concierge and patient care and looking forward to assisting you with all of your aesthetic needs.

Please do not hesitate to call us at **281-242-TIME (8463)** if you have any additional questions regarding your consultation. Visit our website **TimelessPlasticSurgery.com** to review patient testimonials and our before/after gallery.

Sincerely,

Peter Chang, M.D.

And

Concierge Care Staff



*Timeless
Plastic Surgery*



Center of Excellence for Cosmetic Surgery

Patient Safety First

In our surgical facility we emphasize PATIENT SAFETY! We have been inspected and have met 100% of the standards set by AAAASF for accreditation of our surgical facility.

The areas covered during inspection are:

- Personnel: Prove to have current and appropriate credentials of medical staff.
- Operating Room: Prove to have safe surgical equipment, sterile technique, and policies.
- Recovery Room Safety: Prove to have safe equipment, staff, and policies.
- Anesthesia: Appropriate anesthesia equipment, drugs, and qualified providers.
- Quality Assessment/Quality Improvement: Adhere to oversight thru a strict reporting and peer review policy.
- General Environment and Safety: Provide a safe, comfortable, non-threatening, and personal atmosphere in which to have surgery.
- Medical Records: Prove to have complete and accurate medical records.

Modern surgery and anesthesia have reached new heights in safety and new, less invasive procedures have been developed. However, economic pressures have created a trend in outpatient surgery in which all types of physicians are doing surgery in their offices. Many of these physicians are performing procedures learned during a weekend course and in many cases, are a far afield from their training or not in the field of specialty. Another concern is the use of oral or intravenous sedating drugs on patients undergoing these procedures in non-accredited facilities.

AAAASF accreditation assures proper credentials and strict requirements for safeguards prevent this scenario from happening.

AAAASF is unique among accrediting agencies in protecting patients in an office-based surgery (OBS) setting:

- Requires surgeons to have hospital privileges for any procedure that is performed.
- Requires the use of Anesthesia professionals for deeper levels of anesthesia
- Requires safe surgical environment, equipment, drugs, etc. through specific standards
- Holds OBS to hospital standards
- Requires peer review (peer oversight) and tracks data (complications, mortalities, etc. with extensive data covering over 2 million procedures).

TimelessPlasticSurgery.com

1327 Lake Pointe Pkwy, Ste. 300

281-242-TIME(8463)

Sugar Land, TX 77478



PAYMENT OPTIONS

Cash or Equivalent

We accept cash and cash equivalent (i.e. Money order, Cashier's Check, Personal Check [must have 10 business days to clear]). Credit/Debit cards and Financing will not be accepted as cash equivalent.

Credit Card

We accept all major credit and debit cards.

Care Credit

To apply for care credit, please visit **www.carecredit.com** or call 833-893-7864. Care credit offers 6 and 12 months with 0% interest, and monthly statements will start a few weeks after the initial transaction. Care Credit offers 24, 36, 48 months with 14.9% interest. They also offer 60 months at 16.9% fixed interest. To find out your exact monthly payments, please visit the website, and go to "Payment Calculator" located on the homepage. (Care Credit may not be used for Surgical/Procedure Scheduling fees)

Timeless Payment Plan

- To schedule surgery, a minimum of \$1,000 must be placed.
- If you are unable to schedule surgery at that time, you can make payments for (1) year towards your surgery. No fees or interest will be applied, even if our prices change, yours will stay the same!
- Once you have placed your \$1,000, you will be able to make payments weekly or monthly towards your surgery. This can be done over the phone with a credit card, mailing a check or money order, or you can come by the office.
- TPS payment plan does not require a minimum daily/monthly payment; your payment must be paid in full within one year from your first payment. Once surgery has been scheduled, your remaining balance **MUST** be paid in full at least (2) weeks before surgery. This is typically done at the time of your pre-operative appointment.

www.TimelessPlasticSurgery.com

281-242-TIME (8463)



Peter Chang, M.D.

281-242-8463

1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478

Patient Name: _____ Date of Birth: _____

What is the primary reason for you visit today? _____

What additional services would you like to learn about? Please check all that apply.

FACE	BREAST	BODY
<input type="checkbox"/> Blepharoplasty (eyelid lift) <input type="checkbox"/> Brow Bone Reduction <input type="checkbox"/> Brow Lift <input type="checkbox"/> Buccal Fat Pad Removal <input type="checkbox"/> Cheek Augmentation <input type="checkbox"/> Chin Augmentation/Reduction <input type="checkbox"/> Facelift <input type="checkbox"/> Facial Liposuction <input type="checkbox"/> Fat Injection to Face <input type="checkbox"/> Lip Augmentation <input type="checkbox"/> Necklift (platysmaplasty) <input type="checkbox"/> Otoplasty (ear pinning) <input type="checkbox"/> Rhinoplasty <input type="checkbox"/> Timeless Dimple (dimpleplasty) <input type="checkbox"/> Upper Lip Plasty	<input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Breast Implant Exchange <input type="checkbox"/> Breast Implant Removal <input type="checkbox"/> Breast Reconstruction <input type="checkbox"/> Breast Revision <input type="checkbox"/> Breast Reduction (cosmetic) <input type="checkbox"/> Gynecomastia (male breast reduction) <input type="checkbox"/> Mastopexy (breast lift) <input type="checkbox"/> Nipple Reconstruction	<input type="checkbox"/> Body Lift <input type="checkbox"/> Brachioplasty (Arm Lift) <input type="checkbox"/> Buttock Augmentation <input type="checkbox"/> Buttock Lift <input type="checkbox"/> Liposuction <input type="checkbox"/> Thigh Lift <input type="checkbox"/> Timeless Tuck (abdominoplasty w/ contouring liposuction) <input type="checkbox"/> Umbilical Hernia Repair <input type="checkbox"/> Umbilicoplasty <input type="checkbox"/> Vaginal Rejuvenation <input type="checkbox"/> Labiaplasty
OTHER		
<input type="checkbox"/> Earlobe Repair <input type="checkbox"/> Keloid removal <input type="checkbox"/> Cyst Removal <input type="checkbox"/> Mole Removal <input type="checkbox"/> Scar Revision <input type="checkbox"/> Steroid Injection <input type="checkbox"/> Non-Invasive Vaginal & Labial Rejuvenation	<input type="checkbox"/> Botox®/Xeomin® <input type="checkbox"/> Sculptra <input type="checkbox"/> Kybella <input type="checkbox"/> Juvederm® <input type="checkbox"/> Radiesse® <input type="checkbox"/> Restylane® <input type="checkbox"/> TruSculpt <input type="checkbox"/> Emsculpt <input type="checkbox"/> Emsella	<input type="checkbox"/> MiraDry® (sweat reduction) <input type="checkbox"/> Ultherapy® <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Laser Skin Resurfacing <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Sclerotherapy/ Vein injection <input type="checkbox"/> Laser for veins <input type="checkbox"/> Skin Care and Products

Have you had any previous non-invasive procedures? (i.e. fillers, lasers, ect....) ☐ YES ☐ NO

Have you had previous surgeries? ☐ YES ☐ NO _____

If considering surgery, how far in the future would you like to have your surgery? (check one)

☐ Unsure ☐ 1-3 months ☐ 4-6 months ☐ 1+ year

Is there an upcoming occasion or date you are working with? ☐ YES ☐ NO _____

Would you like to discuss financial options? ☐ YES ☐ NO

Cancellation Policy

We may ask you to secure your appointment time with a credit card in the event you do not show up for your appointment, a late notice fee will apply. If you need to cancel or reschedule your appointment, we ask that you please provide us with at least two (2) business days (48 hours) notice to avoid a late notice fee.

Patient/Guardian Signature

Date



Peter Chang, M.D.

281-242-8463

1327 Lake Pointe Parkway, Ste 300

Sugar Land, TX 77478

Patient's Name _____
First Middle Last

Home Address _____
Street /Apt # City State Zip

Home Phone _____ **Cell** _____ **Other** _____

E-mail _____ **Would you like monthly specials emailed?** ☐ YES ☐ NO

Birth date _____ **Age** _____ **Social Security#** _____ **Gender** ☐ Male ☐ Female

Emergency Contact _____ **Relationship to patient** _____ **Phone #** _____

Marital Status ☐ Single ☐ Married to: _____ ☐ Other _____

Employer (Company Name) _____ **Occupation** _____ **Work Phone** _____

Any restrictions for contacting you? ☐ Yes ☐ No **Describe restrictions:** _____

How did you hear about us?

☐ **Magazine** (circle one: Fort Bend Lifestyles, Katy Lifestyles, New Beauty, Other _____)

☐ **Commercial** (circle one: KPRC Channel 2, Comcast Cable, The KUBE Channel 57)

☐ **Friend/Relative/Patient** Name: _____

If you were referred by a patient of ours, may we thank them? ☐ Yes ☐ No

☐ **Internet** (circle one: TimelessPlasticSurgery.com, Google.com, Facebook, Twitter, YouTube, RealSelf, Other _____)

☐ **Billboard**

☐ **Other** _____

I understand that office visit charges are to be paid on the day service is rendered. I understand that my payment contract is between Timeless Plastic Surgery and myself. I understand that Dr. Peter Chang is not contracted with Medicare, Medicaid, or any other insurance, and because they are out-of-network with all insurances, additional fees may apply. I authorize Timeless Plastic Surgery to bill my insurance for non-cosmetic care and charge any third party for my remaining balances. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. Any payments made to Timeless Plastic Surgery or Peter Chang, M.D., including scheduling fees, surgery deposits, consultation fees, and surgeon/facility fees, are non-refundable and processing fees may apply.

I hereby agree that if I seek Dr. Chang's surgical expertise in correcting the results of other surgeons, I will not request Dr. Chang to give any testimony beyond providing a copy of medical records. Participation in lengthy court proceedings prevents Dr. Chang from caring for other patients and will require a fee. Furthermore, I agree to refrain from directly or indirectly publishing or airing negative commentary about Dr. Chang and/or their practices and will use all reasonable efforts to prevent any family members or acquaintances from engaging in such activities. If such activities are performed, I understand and agree to have it removed, retracted and/or stopped immediately at my cost.

I grant consent to the use and disclosure of my photos by Timeless Plastic Surgery, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) protecting patient privacy. I understand that Dr. Chang may use and disclose my health information in order to provide healthcare services, in accordance with HIPAA regulations as described below.

PRIVACY NOTICE -- "Timeless Plastic Surgery Notice of Privacy Practices" describes how your health information may be used and disclosed and how you can get access to that information. A copy of this Notice in its entirety is provided for you to read. Timeless Plastic Surgery (TPS) may use and disclose your health information for treatment, billing, healthcare operations, research, during public health or safety threats posed to you or others, and as required by local, state or federal law. You have the right to request to inspect, receive a copy, amend, or restrict the use and disclosure of your health information. TPS has the right to change this Notice at any time, and you may request a copy at any time.

I acknowledge that I have been informed, understand, and agree to all the terms described above.

Patient/Legal Representative Signature

Printed Name

Date



☐ Peter Chang, M.D.

☐ Consultant

1327 Lake Pointe Parkway, Ste 300

Sugar Land, TX 77478

281-242-TIME (8463) / 281-242-2639 (FAX)

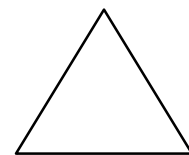
Patient Name _____ DOB _____ Height _____ Weight _____ Sex: **M** **F**

List all medical problems: _____ _____ _____ _____	List all Medications <i>(Including Herbs, diet, etc.)</i> _____ _____ _____ _____	List all surgeries <i>(including cosmetic)</i> _____ _____ _____ _____
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List all drug allergies:

YES NO

- | | | |
|-----|-----|---|
| YES | NO | |
| [] | [] | 1. Have you or a family member ever had a problem with an anesthetic other than nausea? |
| [] | [] | 2. Have you ever or do you now smoke, how much and for how long? |
| [] | [] | 3. Do you drink alcohol? If yes, how much and how often? |
| [] | [] | 4. Are you immunocompromised? HIV? AIDS? |
| [] | [] | 5. Do you have asthma? What induces it? When was your last episode? |
| [] | [] | 6. Do you have high blood pressure? For how long? |
| [] | [] | 7. Do you have a heart murmur? Mitral valve prolapsed? |
| [] | [] | 8. Have you ever had angina, a heart attack, or an abnormal EKG? |
| [] | [] | 9. Have you had a persistent cough more than 3 weeks, coughing up blood, night sweats or fever? |
| [] | [] | 10. Do you ever wake up short of breath or have swelling? |
| [] | [] | 11. Do you have problems walking up a flight of stairs? |
| [] | [] | 12. Do you have "hardening of your arteries"? |
| [] | [] | 13. Have you had kidney disease or require a special diet due to your kidneys? |
| [] | [] | 14. Have you ever had hepatitis or been jaundiced? |
| [] | [] | 15. Do you have a hiatal hernia, acid reflux, or an ulcer? |
| [] | [] | 16. Do you have a cold, cough, or have any breathing difficulty? |
| [] | [] | 17. Have you ever had a stroke? |
| [] | [] | 18. Do you have limb that becomes weak or numb? |
| [] | [] | 19. Have you ever had seizures, loss of vision or speech? |
| [] | [] | 20. Do you have diabetes? For how long? |
| [] | [] | 21. Do you have thyroid disease? |
| [] | [] | 22. Do you have back, neck, or jaw problems? |
| [] | [] | 23. Do you have any bleeding disorders or anemia (low blood count)? |
| [] | [] | 24. Have you taken aspirin, Coumadin, Plavix or Lovenox in the last week? |
| [] | [] | 25. Have you taken any diet medications in the last month? |
| [] | [] | 26. Have you had any disease requiring chemotherapy or radiotherapy? |
| [] | [] | 27. Is there any chance you could be pregnant? Date of last period? _____ |
| [] | [] | 28. Have you ever had a mammogram? Date: _____ |
| [] | [] | 29. Do you or your family have a history of breast cancer? Relationship? _____ |



I attest that the above information is true to the best of my knowledge, and that I have disclosed all medical information. I understand that nondisclosure of any medical information may affect my care. I understand and agree that non-compliance with any instructions may affect my care.

Patient/Guardian Signature

Date

BMI: _____ Size (Waist/Bra): _____ Selected implant: _____ Assessment: _____ _____ Plan: _____ _____ Med Clr (Y/N) Lovenox (Y/N) Overnight (None/Local/Hosp) Anesthesia (IV/Gen) Anes Hrs: _____ Fac. Hrs. _____	<div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Med Clr. <input type="checkbox"/> Multivitamin <input type="checkbox"/> Iron <input type="checkbox"/> MMG </div> Notes: _____ _____ _____ Physician Signature: _____
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Peter Chang, M.D.

281-242-8463

1327 Lake Pointe Parkway, Ste 300

Sugar Land, TX 77478

Cancellation and No Show Policy

Dear Patient,

We Strive to render excellent medical care to you and the rest of our patients. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Schedule Appointments

For a scheduled appointment, please call our office at 281-242-8463 and our staff will try their best to schedule your appointment at the most convenient time possible. As a courtesy, we contact you one (1) business day prior to your appointment to remind you. If we leave you a message, please confirm your appointment by calling or emailing our office during normal business hours.

Cancellation/Rescheduling of an Appointment

In order to be respectful of the "No Show" policy, please be courteous and call our office promptly if you are unable to attend an appointment. We require at least 24-48 hours' notice, so that your appointment time can be reallocated to someone else. **Multiple (more than one) appointment rescheduling will result in a fee of \$50 that will be enforced upon making any new appointments. In addition, failure to make scheduled appointments for procedures will result in the loss of all funds for that procedure.**

Late cancellations will be considered as a "NO SHOW"

No Show policy

A "no show" is someone who misses an appointment without cancelling it at least 24-48 hours in advance or who fails to keep a scheduled appointment. In the event a 24-48 hour notice is not given, a fee of \$50.00 will be charged for missed office visits and for any missed procedures.

Patients who fail to pay the above fee will not be allowed to schedule future appointments until the fee is paid. Multiple Cancellations or No Shows may result in dismissal from our practice.

I have read and understand the Cancellation and No Show Policies of the practice and I agree to the terms.

Patient Name/Guardian Printed: _____

Signature of Patient/Guardian: _____ Date: _____



Peter Chang, M.D.

281-242-8463

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Sugar Land, TX 77478

Notice of Privacy Practices

Acknowledgement of Receipt

Date: _____

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and been asked to review a copy of the Timeless Plastic Surgery Notice of Privacy Practices.

Patient's Signature _____ Date: _____

If completed by the patient's legal representative, please print and sign your name in the space below.

Legal Representative's Name: _____ Date: _____

Legal Representative's Signature: _____ Relation to Patient: _____

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's legal representative.

I have made a good faith effort to obtain a written Acknowledgement of Receipt of the Timeless Plastic Surgery Notice of Privacy Practices but was unable to do so for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign because _____
- ☐ Other _____

Staff Name: _____ Date: _____

TIMELESS PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2015

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

This notice applies to the information and records we have about you, your health, and the health care and services you receive from Timeless Plastic Surgery. Your medical information, also called Protected Health Information (PHI), may include information created and received by us, may be in the form of written or electronic records or spoken words, and may include information about your health history, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, billing and payment activities, and similar types of health-related information.

We are required by law to give you this notice of our legal duties and privacy practices with respect to your PHI, maintain the privacy of your PHI, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PHI We may use and disclose your PHI for the following purposes without your specific written authorization:

For Treatment We may use and disclose your PHI to provide you with medical treatment and services. For example, we may disclose your PHI to doctors, nurses, staff, and other health care professionals within and outside our office to ensure that they have the necessary information to treat you. Family members and friends who are involved in your medical care may also need to know your PHI in order to care for you. We will request your permission before sharing Information with them unless you are unable to give permission due to your health condition.

For Payment We may use and disclose your PHI to bill and receive payment from you, an insurance company, or a third party for the treatment and services you receive from us. For example, we may need to give your health plan information about a service you received here so it will pay us or reimburse you for the service. However, if you pay for the service yourself (i.e. out-of-pocket and without any third party contribution or billing), we will not disclose this PHI to a health plan if you instruct us not to do so.

For Health Care Operations We may use and disclose your PHI to operate our office and make sure that you receive the highest quality of care. For example, we may use your PHI to evaluate the performance of our staff or to help us determine whether certain new treatments are effective. We may disclose your PHI to health plans and other providers for the purpose of helping them provide or improve care, reduce cost, and comply with the law.

For Fundraising We may contact you to ask for your support with fundraising campaigns on our own behalf. If you wish to opt-out of receiving such communications, please notify us in writing, and we will not use or disclose your information for these purposes.

IN SPECIAL SITUATIONS We may use and disclose your PHI for the following purposes when subject to applicable legal requirements without your specific written authorization:

To Avert a Serious Threat to Health and Safety to you and/or others.

As Required By Law and Government Authorities.

To Business Associates who perform functions 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 with them.

For Research Projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are.

For Workers' Compensation in connection to your claim.

For Public Health Reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.

For Health Oversight Activities such as audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

In Lawsuits and Disputes in response to a court or administrative order or subpoena.

To Law Enforcement Officials in response to a court order, subpoena, warrant, summons or similar process.

To Coroners and Medical Examiners in order to identify a deceased person or determine the cause of death.

To Individuals Involved in Your Care or Payment for Your Care if 1) we obtain your verbal agreement to do so, or 2) we give you an opportunity to object to such a disclosure and you do not raise an objection, or 3) we can infer from the circumstances, based on our

professional judgment, that you would not object. For example, we can assume you agree to our disclosure of your PHI when you bring a companion with you into the exam room during an appointment. In situations where you are not capable of giving consent, we may, using our professional judgment, determine that a disclosure is in your best interest and will disclose only the PHI that is relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF YOUR PHI We will use or disclose your PHI for the following purposes, only with your specific written authorization:

For Fundraising and Marketing Purposes where there is financial remuneration

For the Sale of Your PHI

For Disclosure of Your PHI to an Attorney or Employer

For Disclosure of Your Psychotherapy Notes

For Other Uses and Disclosures NOT described in this notice.

If you give us authorization to use or disclose your PHI, you may revoke that authorization, ***in writing***, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding your PHI that we maintain in a *designated record set* (i.e. medical records and billing records we use to make decisions about you).

Right to Inspect and Copy You have the right to inspect and receive a copy of your PHI that is in a designated record set. You must submit a written request to Timeless Plastic Surgery to inspect and/or receive a copy of your PHI. We may deny your request in certain limited circumstances. We will not charge you if you wish to inspect your PHI. Timeless Plastic Surgery staff supervision is required when inspecting your PHI. If you request a copy of your PHI, we will charge a fee for the labor, supplies, and postage per State regulations. We will notify you in advance of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Right to Amend If you believe your PHI in a designated record set is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must submit a written request to Timeless Plastic Surgery. We may deny your request in certain circumstances.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI in a designated record set that was non-authorized or required under special circumstances. You must submit a written request and pay a fee to Timeless Plastic Surgery to receive this list.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use and disclose about you for treatment, payment and health care operations. You have the right to request a limit on PHI we disclose about you to someone who is involved in your care or the payment for it. To request restrictions, you must submit a written request to Timeless Plastic Surgery. If you pay for treatment, services, supplies, or prescriptions out-of-pocket and you request for that information not be communicated to your health plan for payment or health care operations purposes, we will comply with your request. However, we are not required to agree to any other requested restrictions.

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 at work or by mail. To request confidential communications, you must submit a written request to Timeless Plastic Surgery. Your request must specify how or where you wish to be contacted. You need not disclose the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice You have the right to receive a paper copy of this notice at any time.

Right to Breach Notification We will inform you if there is a breach of your unsecured PHI.

CHANGES TO THIS NOTICE We reserve the right to change the terms of this notice and to make the new notice provisions effective for PHI we already have about you as well as any information we receive in the future. We will post the current notice with its effective date in our office as well as on our website. You are entitled to a copy of the notice currently in effect.

QUESTIONS/CONCERNS If you have any questions about this notice, please contact Timeless Plastic Surgery at 1327 Lake Pointe Parkway, Suite 300, Sugar Land, Texas 77478 or call (281) 242-TIME (8463).

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. You will not be penalized for filing a complaint.