Patient Registration Form

All Fields **MUST** be completed - **PRINT clearly**

For Office Use Only:
☐ New patient
Date:____/____/____
☐ Established patient

Entered in Nextgen:_____

Patient Information

Last name	First	MI
Date of Birth	Male Female Transgender	
Address		
City	State	Zip code
Home Phone Number, Is this # Primary? Y N	Cell Phone Number, Is This # Primary? Y N	Work Number
E-mail address		Marital Status **S M D W**
Employer Name & Phone Number		
Spouses Name	Spouses Date of Birth	Spouses Primary Number

Emergency Contact

Last Name	First name	Relationship to Patient
Home Phone Number, Is this # Primary? Y N	Cell Phone Number, Is This # Primary? Y N	Work Number

Primary & Secondary Insurance

Primary Insurance		Insurance Phone Number
Policy Holder's Name	Policy #	Group #
Policy Holder's Date of Birth (**required**)		Policy Holder's Phone Number

Secondary Insurance		Insurance Phone Number
Policy Holder's Name	Policy #	Group #
Policy Holder's Date of Birth (**required**)		Policy Holder's Phone Number

Patients with no insurance will be expected to pay all fees at the time of service.

I understand it is my responsibility to provide correct information and update this office of any changes. The information above is accurate and true as submitted on the date below.

Signature _____ Date _____

Patient Financial Responsibility and HIPAA Agreement

Financial Arrangements: I authorize all insurance or health plan benefits, otherwise payable to me, payable directly to Firehouse Diabetes and Endocrine Center to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance and/or agency, and for all co-payments, deductibles and co-insurance amounts. Further, I understand that it is my responsibility to verify that my PCP has submitted the necessary referral, if applicable, otherwise I may be responsible for the cost of the entire visit.

Payments: Co-payment is due at time of service upon check-in. Co-insurance is due at time of service upon check-out.

Additional Fees:

A $25 statement fee will be added for any balances not paid within the 4 week billing cycle
Account balances outstanding for 16 weeks or longer may be sent to an agency for collections

Appointment Cancellation: I understand that I must telephone the office **a minimum of 24 hour**s in advance of a scheduled appointment to confirm a cancellation.

I understand that if I **cancel my appointment less than 24 hours in advance or do not show up for a scheduled appointment** I will be held responsible for the following charges for the scheduled appointment:

New Patient appointment, $330+
Ultrasound, $ 295+
Fine needle aspiration, $1635+
Follow up appointment, $220+

I understand that my **insurance company will not reimburse the fee** for the missed appointment charge and agree to be fully responsible for the charge. I understand that the office provides a reminder call as a courtesy and that it is my responsibility to maintain my appointments, even in the absence of a reminder call.

Auto Accident/Liability Claim: I understand that if I am being seen for conditions related to an auto accident or other liability claim that Firehouse Diabetes and Endocrine Center cannot wait for legal proceedings to be completed before receiving payment for services. I understand that full payment is expected at the time services are rendered. I understand that I, the patient, am responsible for these charges.

Per HIPPA guidelines medical records will be made available, upon request, within 30 days. A release of information must be filled out and signed before any records are released.

In the event of any overpayment, the monies will be refunded to the appropriate payer.

I have received the HIPAA Notice of Privacy Practices. I have read the above policies and agree to the conditions set therein.

Patient (print): _____

Responsible Party (print): _____ Relationship: _____

Signature: _____ Date: _____

Firehouse Diabetes and Endocrine Center – RECORDS RELEASE FORM

Authorization for Use and Disclosure of Protected Health Information

Patient Name _____

Date of Birth _____

Current Address_____

Daytime phone _____ Cell Phone _____

Reason for Request:
- □ Personal
- □ Medical Care
- □ Benefits
- □ Worker's Comp
- □ Permanent Transfer to New Provider
- □ Other

I AUTHORIZE INFORMATION RELEASE ***FROM***

INFORMATION TO BE RELEASED ***TO***

* Note: If no address provided it may cause a delay in your request *

FROM:

_____
Name of Facility/Provider

_____
Address

_____
City, State, Zip

TO:

_____
Facility/Provider to Receive Information

_____
Address

_____
City, State, Zip

Type of Information to be Released

Specific Information Only Please

- □ Chart Notes
- □ Laboratory Results
- □ X-Ray Reports/Films
- □ Emergency Room Report
- □ Immunization Records
- □ Medication Records
- □ Discharge Summary
- □ Operative Report
- □ Other _____

□ Most Recent Visit □ Medical Records from _____ to _____ □ Last 2 years

Note: If checkbox if not selected, the last 6 months will be copied/printed. **There may be fees for providing copies.**

Protected or Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV / AIDS information
Initials

_____Mental Health Information
Initials

_____ Drug / Alcohol diagnosis, treatment or referral information
initials

_____ Genetic Testing Information
Initials

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that federal law or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

_____
Signature of Patient or Patient's Legal Representative

_____
DATE

_____
PRINT Patient's Name or Name of Legal Representative

_____
Relationship to Patient

1585 Liberty St. SE Salem, OR 97302 503-589-0565 FAX 503-589-0463

Authorization to Release Protected Health Information (PHI)

Today's Date: _____

Patient Name (print): _____

I hereby give my written permission for Firehouse Diabetes and Endocrine Center to speak with the following **(please include full name and relationship**) **NOT including your Physicians.**

If you are choosing not to list anyone, please write **NONE** on the line below.

_____

_____

_____

Regarding (please check all that apply)

- ❑ Medical Information including Lab Results
- ❑ Appointment Scheduling or Rescheduling
- ❑ Billing and Insurance
- ❑ Other _____

I authorize Firehouse Diabetes and Endocrine Center to leave a detailed message at this number: _____

I understand Firehouse Diabetes and Endocrine Center can **only** speak with the persons I have listed above. I may revoke this permission at any time in person or by written request.

Signature: _____ Date:

Witness: _____ Date:

Firehouse Diabetes & Endocrine Center

Phone 503.589.0565 * Fax 503.589.0463 * 1585 Liberty St. SE * Salem, OR 97302

New Patient Questionnaire

(All Fields **MUST** be completed)

Today's Date _____

1. Patient Info

Last Name		First and Middle		DOB
Male ☐ Female ☐ Transgender ☐	Primary Language	Ethnicity	Race	Marital Status **S D M W**
Preferred Pharmacy (Name and Location)		Primary Care Provider		Occupation
Referring Doctor				

2. History of Present Illness

What is your health concern at this time and what is the reason for your visit?

_____

3. Medical History

Please indicate if you have ever experienced or are being treated for any of the following conditions. Please indicate the date of onset if known.

□ Alcohol dependence	____/____/_____	□ Hay Fever/Allergies	____/____/_____	□ Low blood pressure	____/____/_____
□ Anemia	____/____/_____	□ Headache	____/____/_____	□ Migraines	____/____/_____
□ Anxiety	____/____/_____	□ Heart attack	____/____/_____	□ Obesity	____/____/_____
□ Arthritis	____/____/_____	□ Heart Disease	____/____/_____	□ Osteoporosis	____/____/_____
□ Asthma	____/____/_____	□ Heart failure	____/____/_____	□ Positive TB skin test	____/____/_____
□ Cancer		□ Other heart condition		□ Rheumatoid arthritis	____/____/_____
Type:					
_____	____/____/_____	_____	____/____/_____	□ Seizures	____/____/_____
□ Cataracts	____/____/_____	□ High blood pressure	____/____/_____	□ Sleep apnea	____/____/_____
□ Congestive heart failure	____/____/_____	□ High cholesterol	____/____/_____	□ Stroke (CVA)	____/____/_____
□ COPD	____/____/_____	□ Hyperthyroidism	____/____/_____	□ Tuberculosis	____/____/_____
□ Depression	____/____/_____	□ Hypothyroidism	____/____/_____	□ Ulcers	____/____/_____
□ Diabetes type I	____/____/_____	□ Other Thyroid disease	____/____/_____	□ Vitamin Deficiency	____/____/_____
□ Diabetes type II	____/____/_____	□ Hepatitis	____/____/_____	□ Other: _____	____/____/_____
□ Emphysema	____/____/_____	□ Other kidney disease		□ Other: _____	____/____/_____
□ Esophageal reflux	____/____/_____	_____	____/____/_____	□ Other: _____	____/____/_____
□ GERD	____/____/_____	□ Irregular heart rhythm	____/____/_____	□ Other: _____	____/____/_____
□ Goiter	____/____/_____	□ Insomnia	____/____/_____	□ Other: _____	____/____/_____
□ Gout	____/____/_____	□ Liver disease	____/____/_____	□ Other: _____	____/____/_____

4, Surgical History

Please list all surgeries, procedures or hospitalizations. Please include date if possible

Description	Dates	Description	Dates
1.) _____	_____/_____/_____	4.)_____	_____/_____/_____
2.) _____	_____/_____/_____	5.)_____	_____/_____/_____
3.) _____	_____/_____/_____	6.)_____	_____/_____/_____

Name:	DOB:

5. Family Health History –

Complete page 11 of this document. It is required to include the first name of each relative noted: (example : Mother – Victoria)

6. Social History/Habits

Who lives in your household? (relationship, names, ages)			
Do you have children? Yes ☐ No ☐	How many sons?	How many daughters?	Previously been divorced? Yes ☐ No ☐ How many times?
Are you currently employed? Retired ☐ What is or was your occupation? Yes ☐ No ☐ Disabled ☐			

Do you currently smoke cigarettes? Yes ☐ No ☐	For how many years?	How many packs per day?	Have you ever tried to quit? Yes ☐ No ☐
Have you smoked in the past? Yes ☐ No ☐	For how many years?	How many packs per day?	Year quit?

Do you use caffeine? Yes ☐ No ☐	Coffee ☐ Soda ☐ Tea ☐	How much?	How often?
Do you drink alcohol? Yes ☐ No ☐	Beer ☐ Wine ☐ Liquor ☐	How much?	How often?
Do you use recreational drugs? Yes ☐ No ☐	Have you in the past? Yes ☐ No ☐	Do you have a Medical Marijuana card? Yes ☐ No ☐	

Do you exercise? Yes ☐ No ☐	What type?		How often?			
What type of diet do you have? (please mark the appropriate box)	Diabetic	1600 calorie	1800 calorie	2000 calorie	Vegan/vegetarian	Other:

Name:	DOB:

7. Medications (prescription, non-prescription, vitamins, minerals, herbs)

Please list all current medications. Include name, dosage and frequency taken. Please attach page if more space is needed.

Name of medication	Dosage	Directions

8. Allergies to Medications

Please list allergen and reaction

☐ No Known Drug Allergies

Allergen	Reaction experienced

9. Immunizations

	Date of last		Date of last
Influenza Do you get yearly? □ Yes □ No	____/____/_____	Tetanus, Diphtheria, Pertussis (Tdap)	____/____/_____
Pneumococcal (PPV23) After age 65? □ Yes □ No	____/____/_____	Shingles (Zostavax)	____/____/_____

Name:	DOB:

10. Health Maintenance

	Date of last		Date of last
Lipid Panel	____/____/_____	Gynecology Exam	____/____/_____
TSH	____/____/_____	PAP	____/____/_____
BMP/CMP	____/____/_____	Mammogram	____/____/_____
HgA1C	____/____/_____	EKG	____/____/_____
Stool card for hidden blood	____/____/_____	Eye Exam	____/____/_____
Sigmoidoscopy	____/____/_____	DEXA/Bone scan	____/____/_____
Colonoscopy	____/____/_____	Chest x-ray	____/____/_____

11. Review of Systems

How would describe your general health? □ Excellent □ Good □ Fair □ Poor

Check any items that apply to you:

GENERAL:

- □ Tire easily/fatigued – If YES, rank on a scale of 0 – 10 with 0 the worst and 10 the best _____.
- □ Fever
- □ Chills
- □ Weight Change: □ Lost or □ Gained, more than 10 pounds in the past year without trying.
- □ Trouble Sleeping: □ going to sleep □staying asleep □ both
- □ Poor Appetite

HEENT:

Date of your last eye exam: _____

If Diabetic: Do you have Diabetic Retinopathy? □ Yes □ No □ Don't Know

- □ Trouble with your eyes or vision, please explain _____
- □ Severe head injury, Date _____
- □ Chronic or severe headaches
- □ Hearing loss
- □ Trouble with balance
- □ Hay fever/seasonal allergies
- □ Sinus Infections
- □ Hoarseness
- □ Sore Throat

CV/PULMONARY:

Have you had an EKG? □ Yes, Date _____ □ No □ Don't Know

Have you had a cardiac stress test? □ Yes, Date _____ □ No □ Don't Know

- □ Chest pain
- □ Chest pressure
- □ Heart palpitations
- □ Shortness of breath
- □ Difficulty breathing
- □ Pain with breathing
- □ Swelling of legs/ankles
- □ Chronic cough

Name:	DOB:

GASTROINTESTINAL TRACT:

- □ Heartburn/GERD/Acid Reflux
- □ Trouble with swallowing
- □ Nausea How often? _____
- □ Vomiting How often? _____
- □ Diarrhea
- □ Constipation
- □ Stomach pain
- □ Ulcers
- □ Blood or recent change in bowel movements, please explain: _____

  Have you had a □ Colonoscopy or □ Flexible Sigmoidoscopy? If yes, when? _____

GENITOURINARY:

- □ Pain with urination
- □ Difficulty urinating
- □ Difficulty holding your urine (incontinence)
- □ Frequent urination
- □ Getting up at night to urinate. If yes, how many times on average per night? _____
- □ Kidney stones. If yes, how many times, and when was the last time? _____
- □ History of urinary tract infections. When was the last infection? _____
- □ Decline in kidney function. Do you see a kidney specialist? □ Yes □ No

NEUROLOGICAL:

- □ Loss of consciousness. When? _____
- □ Seizures
- □ Weakness
- □ Numbness/tingling in □ Hands □ Feet □ Other
- □ Tremors
- □ Paralysis. Where? _____

MUSCULOSKELETAL:

- □ Joint pain. Where? _____
- □ Muscle pain. Where? _____
- □ Any problems with your feet? Please explain _____

  Do you see a podiatrist (foot doctor) for foot care? □ Yes □ No

ENDOCRINE:

- □ Hot compared to others
- □ Cold compared to others
- □ Females: Excessive facial hair
- □ Increased thirst □ Increased urination
- □ Known thyroid disease
- □ Height loss. How much? _____
- □ Osteoporosis
- □ DXA Scan to measure bone mass density. When? _____

HEMATOLOGIC:

- □ Anemia (low blood iron)
- □ Easy bruising

Name:	DOB:

DERMATOLOGIC:

- □ Rashes
- □ Ulcers or sores that do not heal
- □ Changes in skin color
- □ Excessive itching
- □ Excessive sweating
- □ Dry skin
- □ Dry hair
- □ Hair loss

REPRODUCTIVE:

- □ Any sexual problem you wish to discuss? _____

Males: Able to achieve erections □ Yes □ No
Enlarged prostate □ Yes □ No
Hernia □ Yes □ No
Perform testicular self-examinations □ Yes □ No

Females: Date of last menstrual cycle _____
Regular monthly cycles? □ Yes □ No
Date of last PAP/Pelvic exam _____
Perform monthly self breast exam □ Yes □ No
Have you had a mammogram? □ Yes □ No Date: _____
Taking or previously taken estrogen supplements □ Yes □ No

PSYCHIATRIC:

- □ Depression
- □ Mood changes
- □ Difficulty concentrating
- □ Difficulty with memory
- □ Nervousness
- □ Anxiety

Please check any of the events that have happened in the past year:

- □ Marriage
- □ Divorce
- □ Separation
- □ Change of residence
- □ Death of spouse/partner or close friend
- □ Major illness or death in the family
- □ Retirement or change in job

* Please make sure you have written <u>your name</u> and <u>your date of birth</u> at the top of each page.

Thank you for taking the time to complete this questionnaire.

5. Family Health History

Have any of your biological family members experienced any of the following conditions? Please check box if effected.

Check if Family Health History is Unknown ☐

Relationship	Name	Current Age (if still living)	Good Health	Cancer or Malignancy	Alcoholism	Arthritis	Allergies	Asthma	Blood Disease	COPD	Diabetes	Heart Attack	Heart Disease	Hepatitis (Liver Disease)	High Blood Pressure	High Cholesterol	Kidney Disease	Nerve Disease (cerebral palsy, epilepsy, ms)	Psychiatric Problems (nervous breakdown)	Osteoporosis	Stroke	Thyroid Condition	Tuberculosis	Cause of Death / Age at Death
Mother																								
Father																								
Maternal																								
Grandfather																								
Grandmother																								
Paternal																								
Grandfather																								
Grandmother																								
Spouse																								
Child																								
Other																								

PLEASE DO NOT RETURN THESE TWO PAGES PRIVACY PRACTICE TO THE OFFICE

NOTICE OF PRIVACY PRACTICES –*Your COPY*

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

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, procedures, prescriptions, related billing activity and similar types of health related information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example: Your doctor may be treating you for diabetes and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care.

For Payment: We may use and disclose information about you so that the treatment and services you receive at this office may be billed to and payment received from you, an insurance company or a third party. For example: We may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example: We may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping provide or improve care, reduce cost, coordinate and mange health care and services, train staff and comply with the law.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We may disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donations bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you 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.

Health Oversight Activities: We may disclose health information to a health oversight agency for 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.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

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.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you and opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency) we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* If you give us *Authorization* to use or disclose health information about you, 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*, be we cannot take back any uses or disclosures already made with your permission. In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Office Manager in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment as long as the information is kept by the office. To request an amendment, complete and submit a Medical Records Amendment/Correction Form to the Office Manager. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep
- You would not be permitted to inspect or copy
- Is accurate and complete

Right to an Accounting of Disclosures: You have a right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization. To obtain this list, you must submit your request in writing to the Office Manager. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. You request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or sidclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who in involved in your care of the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the Request for Restrictions on Use/Disclosure of Medical Information to the Office Manager.

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 my mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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 it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Office Manager or check-in receptionist.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice (or a summary of the current notice) in the office with it effective date in the top right hand corner. You are entitled to a copy of the notice currently if effect.

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 Office Manager. *You will not be penalized for filing a complaint.*