

# 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<br><span style="float: right;">S    M    D    W</span> |                        |
| 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

|   |          |                              |
|---|----------|------------------------------|
| <b>Primary Insurance</b>                          |          | Insurance Phone Number       |
| Policy Holder's Name                              | Policy # | Group #                      |
| Policy Holder's Date of Birth ( <b>required</b> ) |          | Policy Holder's Phone Number |

|   |          |                              |
|---|----------|------------------------------|
| <b>Secondary Insurance</b>                        |          | Insurance Phone Number       |
| Policy Holder's Name                              | Policy # | Group #                      |
| Policy Holder's Date of Birth ( <b>required</b> ) |          | 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 hours** 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 HIPAA 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

|                                      |                   |    |             |
|--------------------------------------|-------------------|----|-------------|
| Last name                            | First             | MI | DOB         |
| Primary Phone Number    Home    Cell | Cell Phone Number |    | Work Number |

Reason for Request: Personal    Medical Care    Benefits    Worker's Comp    Transfer of care to New Provider    Other

I AUTHORIZE INFORMATION RELEASE **FROM**

INFORMATION TO BE RELEASED **TO**

\_\_\_\_\_  
Name of Facility/Provider

\_\_\_\_\_  
Name of Facility/Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
City, State, Zip

I understand that Firehouse Diabetes and Endocrine Center may not condition my treatment on whether I sign this authorization form unless specified above under Reason for Request. I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Firehouse Diabetes and Endocrine Center. Unless revoked, this authorization will expire in 180 days or on the following date or event \_\_\_\_\_.

**I authorize Firehouse Diabetes and Endocrine Center to use and disclose the protected health information specified below.**

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT Patient's Name or Name of Legal Representative

\_\_\_\_\_  
Relationship to Patient

**Type of Information to be Released**

Specific Information Only Please

|  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Chart Notes           | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Laboratory Results    | <input type="checkbox"/> Medication Records   | _____                                |
| <input type="checkbox"/> X-Ray Reports/Films   | <input type="checkbox"/> Discharge Summary    | _____                                |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Operative Report     |                                      |

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.

|  |  |
|--|--|
| _____<br>Initials    HIV / AIDS information                                      | _____<br>Initials    Mental Health Information   |
| _____<br>initials    Drug / Alcohol diagnosis, treatment or referral information | _____<br>Initials    Genetic Testing Information |

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.

# 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.

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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 <input type="checkbox"/>          | Female <input type="checkbox"/> | Primary Language      | Ethnicity | Race       |
| Transgender <input type="checkbox"/>   |                                 |                       |           |            |
| 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?

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## 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.

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

|              |             |
|--------------|-------------|
| <b>Name:</b> | <b>DOB:</b> |
|--------------|-------------|

### 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?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>       | How many sons?  | How many daughters?             | Previously been divorced?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> How many times? |
| Are you currently employed?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | Retired <input type="checkbox"/><br>Disabled <input type="checkbox"/> | What is or was your occupation? |   |

|  |                     |                         |  |
|--|---------------------|-------------------------|--|
| Do you currently smoke cigarettes?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | For how many years? | How many packs per day? | Have you ever tried to quit?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you smoked in the past?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>       | For how many years? | How many packs per day? | Year quit?   |

|  |   |   |            |
|--|---|---|------------|
| Do you use caffeine?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>           | Coffee <input type="checkbox"/> Soda <input type="checkbox"/> Tea <input type="checkbox"/>  | How much?   | How often? |
| Do you drink alcohol?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>          | Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/> | How much?   | How often? |
| Do you use recreational drugs?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | Have you in the past?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>           | Do you have a Medical Marijuana card?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |            |

|  |            |              |              |              |                  |        |
|--|------------|--------------|--------------|--------------|------------------|--------|
| Do you exercise?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | What type? |              | How often?   |              |                  |        |
| What type of diet do you have?<br>(please mark the appropriate box)          | Diabetic   | 1600 calorie | 1800 calorie | 2000 calorie | Vegan/vegetarian | Other: |

|              |             |
|--------------|-------------|
| <b>Name:</b> | <b>DOB:</b> |
|--------------|-------------|

**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 |
|--------------------|--------|------------|
|                    |        |            |
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**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<br>Do you get yearly? <input type="checkbox"/> Yes <input type="checkbox"/> No       | ___/___/___  | Tetanus, Diphtheria, Pertussis (Tdap) | ___/___/___  |
| Pneumococcal (PPV23)<br>After age 65? <input type="checkbox"/> Yes <input type="checkbox"/> No | ___/___/___  | Shingles (Zostavax)                   | ___/___/___  |

|              |             |
|--------------|-------------|
| <b>Name:</b> | <b>DOB:</b> |
|--------------|-------------|

**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



|              |             |
|--------------|-------------|
| <b>Name:</b> | <b>DOB:</b> |
|--------------|-------------|

**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? \_\_\_\_\_

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**HEMATOLOGIC:**

- Anemia (low blood iron)
- Easy bruising

|              |             |
|--------------|-------------|
| <b>Name:</b> | <b>DOB:</b> |
|--------------|-------------|

**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 your name and your date of birth at the top of each page.

*Thank you for taking the time to complete this questionnaire.*



# **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 manage 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*, but 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. Your 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 disclose 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 is 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 its effective date in the top right hand corner. You are entitled to a copy of the notice currently in 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.*