NASHVILLE FAMILY MEDICINE

PO Box 127
103 Willow Street, Suite B
Nashville, IN 47448

Nashville Family Medicine
Patient Information Brochure

To Our Patients:

Thank you for choosing Nashville Family Medicine as the health care provider for you and your loved ones. We appreciate the opportunity to assist you with your healthcare needs and pride ourselves on the excellent care and quality treatment you will receive from our fine staff. We accomplish this in several ways. This brochure has been created to help answer questions you may have regarding our office.

Office Hours:

Nashville Family Medicine is open Monday, Wednesday, and Thursday 7:30AM-5:00PM, Tuesday and Friday 7:00AM-4:00PM, and Saturday 8:00AM-12:00PM. Our office phone number is 812-988-2223. If you should have an emergency outside of our normal business hours you may reach the doctor on call through the Columbus Regional Hospital operator at 1-800-841-4938. If you have a life-threatening emergency go directly to the nearest hospital emergency room.

Appointments:

When scheduling an appointment with our office please explain the reason for your visit when you phone for your appointment. This will allow us to schedule the appropriate time needed to address your healthcare needs. If this is your first visit with us, please arrive 15 minutes prior to your appointment time so that we may obtain the information we require in order to bill your insurance carrier for you. Please bring your insurance cards with you because we will need to make a copy of your card for billing purposes. In addition please be sure to bring a list of your current medications with you each visit. Walk-in visits for acute illnesses or injuries are accepted if you are willing to wait. Scheduled patients will always be seen first except in the case of emergencies.

If you find that you are unable to keep your appointment we do request that you notify our office as soon as possible, but no later than 24 hours prior to your appointment. This will allow us to utilize the time reserved for you for another patient who may be ill. Maintaining good health requires timely medical care and follow-up. It is our policy that if a patient misses 3 appointments within a 6-month time period **without** providing prior notification to us they will be discharged from our practice.

- *Please inform our front desk staff of any change in address, telephone number, insurance coverage or employment.*
- *Please inform the nurse of any change in medications or medical history.*

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Illness Visits:

For the convenience of our patients we have hours on Saturday from 8:00 AM - 12:00 noon for **established patients only.** These clinic hours are for acute illnesses only. If you are experiencing problems with a chronic problem you will need to schedule an appointment during our regular business hours.

Medical Test Results:

Please allow 7-10 working days for test completion. For lab, x-ray or any other test results, the doctor or nurse practitioner will either call you or mail you a card with those results as soon as they are available or you will be scheduled for a return appointment to go over your results. Staff members will not give test results over the phone.

Prescription Refills:

Prescription refills will only be authorized during normal office hours. All refill requests require a 48 hour notice. When you call please have the following information ready: patient name and date of birth; prescription name and number; pharmacy name and telephone number. Please evaluate your medication supply prior to your office visits and request your healthcare provider to write your refill prescriptions at the time of your visit. If you have not seen your healthcare provider within a 6-month period of time you will need to make an appointment before any refills can be authorized. If you need more than three refills you will need to make an appointment to be seen. We cannot refill any narcotics without seeing you first in the office. If you utilize a mail in pharmacy we will write the prescription, but it becomes your responsibility to mail it in. If you should become ill or begin experiencing symptoms of illness an appointment for an evaluation is required before any medication can be prescribed. This is necessary to insure you receive the appropriate treatment course for your current illness.

Medical Records:

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission.

There may be times when you may request that we provide copies of our records on you to other entities. We do incur an expense to provide you with this service and that cost will be passed on to you. Our fee for copies is $15 that includes copying up to15 pages. There is a $0.25 charge for each additional page plus postage cost. If the cost for the copies is not reimbursed by the receiving entity that you have authorized to obtain these records you will be responsible for payment before the records can be released.

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Form Completion:

There is a standard fee for any form completion including FMLA forms. This amount is per form and based on the number of pages per form. This amount is due at the time the forms are submitted to our office. Please allow 3 working days for processing.

Questions:

We have an excellent staff that is well trained in assisting patients. They are available to assist you with any medical concern or billing question you may have. For medical questions please give a detailed message to a member of our qualified staff and a phone number where you can be reached. The nurse will return your call as soon as she has the opportunity to talk to your healthcare provider about your questions or concerns. Our staff is here to help you.

Insurance and Payment for Services:

We are contracted with several insurance plans. It is our policy and a requirement of our provider contract with your insurance company to collect all co-pays and deductibles at the time of your visit from you. Payment is expected at the time of service. For your convenience we accept cash, checks, MasterCard and Visa credit cards. As a courtesy we will file your insurance claim for you. Accurate insurance information is vital for processing your claims. Please provide any new information regarding your insurance to the front desk. Please remember that insurance is considered a method of reimbursing the member for fees paid to the doctor and is not a substitute for payment. Payment for the account remains your responsibility.

We strive to have a mutually respectable relationship with all of our patients. As part of that relationship we believe it is important that you maintain your account with our office in good standing. Should your account become delinquent and you default on payment of your debt your account will be turned over to an outside collection agency. Should this become necessary you will be responsible for all additional expenses incurred to collect this outstanding debt including the collection agency fees and any associated court costs. Should this become necessary you will also be discharged from the practice.

Thank you for allowing us to care you.

PLEASE PRINT

TODAY'S DATE _____

PATIENT REGISTRATION

PLEASE COMPLETE ALL WHITE AREAS

PATIENT INFORMATION
The person seeing the doctor.

PATIENT NUMBER							
LAST NAME		FIRST NAME & INITIAL					
ADDRESS LINE 1							
ADDRESS LINE 2							
CITY				STATE		ZIP	
HOME PHONE							
SEX		MARITAL STATUS (M/S)		DATE OF BIRTH		M.D. REQUESTING YOUR APPOINTMENT	
PATIENT'S S.S. NO.		IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW Q PATIENT Q YELLOW PAGES Q PROVIDER BOOK Q OTHER					
PATIENT'S EMPLOYER							
EMPLOYER ADDRESS							
CITY				STATE		ZIP	
EMPLOYER PHONE		EXT.					

GUARANTOR
Person responsible for all unpaid balances on the account.

RESP. PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
CITY		STATE		ZIP		E-MAIL ADDRESS	
HOME PHONE		CELL PHONE		PAGER NUMBER			
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.					
RESP. PARTY EMPLOYER		EMPLOYER PHONE		EXT.			
EMPLOYER ADDRESS				EMPLOYER FAX #			

INSURANCE
List all insurance for which you have a current card. List Medicare or Medicaid first.

MEDICARE/MEDICAID OR INS. #1 NAME			INS. #1 CODE	
INSURANCE #1 ADDRESS			INS. #1 PHONE	
POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP	
CERTIFICATE #		GROUP NO.	MEMBER NO.	
INSURANCE #2 NAME			INS. #2 CODE	
INSURANCE #2 ADDRESS			INS. #2 PHONE	
POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP	
CERTIFICATE #		GROUP NO.	MEMBER NO.	
INSURANCE #3			INS. #3 CODE	
INSURANCE #3 ADDRESS			INS. #3 PHONE	
POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP	
CERTIFICATE #		GROUP NO.	MEMBER NO.	

Spouse, step-parent, significant other.

NAME			
DATE OF BIRTH		S.S. NO.	
EMPLOYER		WORK PHONE	
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE	

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

Patient Registration Continued:

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL _____

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INITIAL _____

PATIENT'S SIGNATURE _____ **DATE** _____

Parent/Guardian _____ **DATE** _____

Do you have a Living Will? Yes_____ No_____

A Copy may be needed for your chart. A Copy Was Received By This Office. DATE _____

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of ***NOTICE OF PRIVACY PRACTICES:***

INITIAL_____ **DATE** _____

I give permission for protected Health Care information regarding myself to be shared with the following individuals:

_____

_____

_____

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail: I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

PHONE NUMBER _____ **INITIAL** _____

NASHVILLE FAMILY MEDICINE

New Patient Medical History Form

Name: _____ DOB: _____ Date: _____

Please list all **Medication Allergies**: _____

Medications: Please list any medications you take regularly.

Name	Dosage	Directions	What for?
Name	Dosage	Directions	What for?
Name	Dosage	Directions	What for?
Name	Dosage	Directions	What for?
Name	Dosage	Directions	What for?

Please list all **Chronic Illnesses and Past Medical Illnesses**: _____

Have you ever been injured in an accident? If so, when and what injuries did you receive? _____

Have you ever had any surgeries or been hospitalized for an illness? If so, please list the date and reason.

Have you had any other health issue not already listed? If so, please list. _____

NASHVILLE FAMILY MEDICINE

New Patient Medical History Form

Social History:

Smoking History?
O Yes O No Packs per Day?_____ # of years?_____

Alcohol Use?
O Yes O No Type of alcohol?_____How often?_____# of years?_____

Street Drug Use?
O Yes O No What type of drugs?_____How often?_____

Do you exercise?
O Yes O No Type of exercise?_____How often?_____

What type of diet do you follow?
O Regular O Low fat O Other _____

Do you consume caffeine?
O Yes O No How much? _____

Do you take calcium supplements? O Yes O No Number of dairy servings per day? _____

What is your Occupation?

_____

Spouse's Occupation?

_____

Do you wear a seat belt in the car? O Always O Never O Most of the time

Women only - Do you regularly do self breast exams? O Yes O No

Do you use sunscreen when you are outside? O Always O Most of the time O Occasionally O Never

Have you ever been sexually abused? O Yes O No

What is your highest level of education? O Elementary O HS O College_____O Technical/Trade School _____

Where do you currently live?
O Own Home O Rent O Modular O Apartment O Other_____

With whom do you currently reside?
O Spouse O Parent/s O Significant Other O Grandparent O Alone O Other

Place of Birth_____Have you traveled out of the country? O Yes ONo Where?_____

Do you enjoy any hobbies? O Yes O No What type?_____

NASHVILLE FAMILY MEDICINE

New Patient Medical History Form

Family History:

Father	O Yes	Age:_____	Any Illnesses?_____
	O No	Age at Death:_____	Cause of Death:_____
Mother	O Yes	Age:_____	Any Illnesses?_____
	O No	Age at Death:_____	Cause of Death:_____
Sibling #1	O Yes	Age:_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____
Sibling #2	O Yes	Age:_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____
Sibling #3	O Yes	Age:_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____
Sibling #4	O Yes	Age_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____
Husband/Wife	O Yes	Age_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____
Son/Daughter	O Yes	Age_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____
Son/Daughter	O Yes	Age_____	Any Illnesses?_____
	O No	Age at Death_____	Cause of Death:_____

Others:_____

Has any blood relative ever had:	If yes, please specify who?
O Cancer	_____
O High Blood Pressure	_____
O Diabetes	_____
O Heart Trouble	_____
O Stroke	_____
O Epilepsy	_____
O Tuberculosis	_____
O Nervous Breakdown	_____
O Suicide	_____

NASHVILLE FAMILY MEDICINE

Review of Systems

Are you currently experiencing any of the following problems or symptoms?

Name:_____DOB:_____Date:_____

CONSTITUTION	YES	NO
Fever or chills		
Poor Appetite		
Weight Loss		

EYES	YES	NO
Visual Changes		
Eye Pain		

HEAD AND NECK	YES	NO
Headaches		
Trouble Swallowing		
Mouth Sores		
Runny Nose		
Snoring		
Decreased hearing or ringing in ears		
Ear Pain		

RESPIRATORY	YES	NO
Cough		
Shortness of Breath/decrease in exercise capacity		
Wheezing		

CARDIOVASCULAR	YES	NO
High Blood Pressure		
Chest Pain		
Palpitations		

GASTROINTESTINAL	YES	NO
Nausea or vomiting		
Heartburn or indigestion		
Abdominal Pain		
Diarrhea or constipation		
Blood in the stool or black "tarlike" stools		
Rectal Pain		
Change in bowel movements		
Gas or Belching		

GENITOURINARY	YES	NO
Involuntary loss of urine		
Pain/burning with urination		
Change in color of urine		
Blood in the Urine		

MUSCULOSKELETAL	YES	NO
Neck or back pain		
Pain, swelling or stiffness in joints		
Muscle pain		

NEUROLOGICAL	YES	NO
Dizziness or lightheadedness		
Weakness		
Fainting		
Seizures		
Numbness or tingling		
Speech Difficulties		

PSYCHIATRIC	YES	NO
Do you have trouble sleeping?		
Do you feel tired all the time?		
Do you feel nervous, tense or stressed?		
Do you feel depressed or "down in the dumps"?		

ENDOCRINE	YES	NO
Increased thirst or urination		
Feelings of being hot or cold		

ALLERGIES	YES	NO
Asthma		
Sneezing or itchy watery eyes		
Skin rashes		

SKIN	YES	NO
Rashes		
Exzema		
Psoriasis		

GENERAL QUESTIONS	YES	NO
Any new medical problems since you were last seen?		
Have you had more than one sexual partner over the past year?		
Are you currently using illegal drugs?		

FOR WOMEN ONLY	YES	NO
Lump in breast		
Bleeding or discharge from breast		
Abnormal vaginal bleeding or discharge		
Have you been hit or threatened in the past year?		
Do you use contraception?		
Pain with intercourse		
Date of last menstrual period:_____		
Loss of sexual desire		

FOR MEN ONLY	YES	NO
Testicular swelling or pain		
Loss of sexual function		
Do you get up frequently at night to urinate?		
Penile rash or discharge		
Pain with intercourse		

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Privacy Officer or Office Manager for assistance.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you with your authorization

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Privacy Officer** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the **Privacy Officer**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Privacy Officer** in order to inspect and/or obtain a copy of your IIHI. Our

practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Privacy Officer**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Privacy Officer**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Privacy Officer**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Privacy Officer**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the **Privacy Officer.**