REMEDY

Remedy Behavioral Health, LLC
Patient Registration Form

Phone: 888 460 1290 Fax: 256 320 7776 120 South Locust St
Florence AL 35630

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____ SS#: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Alternate #: _____

Email: _____ Marital Status: _____

May we use the above info to contact you via text ☐Y ☐N Email ☐Y ☐N USPS ☐Y ☐N

Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Decline

Race: ☐Caucasian ☐African American ☐Asian ☐American Indian or Alaskan Native ☐Native Hawaiian or Other Pacific Island ☐Other

POA / Guarantor (if patient is less than 18 years old) _____

Primary Care Provider: _____ Preferred Pharmacy: _____

Pharmacy Location / Address: _____

Emergency contact: _____ Phone #: _____

Primary Insurance: _____ Contract #: _____

Subscriber: _____ Relationship to patient: _____ Subscriber DOB: _____

Group#: _____

Secondary Insurance: _____ Contract #: _____

Subscriber: _____ Relationship to patient: _____ Subscriber DOB: _____

Group#: _____

I authorize my insurance benefits be paid directly to the physician. I authorize the release of necessary information to third party payers/insurance companies and pharmacies to process my claims or fill prescriptions. If my insurance denies services, I understand that I will be responsible for any balance. I understand as the patient it is my responsibility to verify my benefits. ***Initial*** _____

I understand and agree that it is my responsibility to know if my insurance has any deductible, copay, co-insurance, out-of-network, visit limit, prior authorization requirements, referral requirements, or any other type of benefits limitation for the services I receive. ***Initial:*** _____

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Insurance Claims and Filing:

Remedy Behavioral Health is committed to providing you with quality care. To achieve this result, we must highlight that as your provider our relationship is with you not your insurance company. While filing insurance claims is a courtesy we extend to all our patients, all charges are ultimately your responsibility. It is your responsibility to know your insurance benefits; please direct any questions concerning your coverage to your insurance company. Proof of current, valid insurance must be provided at time of service. If you do not provide this information, you will be considered a self-pay patient, and will be required to pay the full charge prior to being seen. We participate in most insurance plans however; it is your responsibility to check with your plan prior to your visit to make sure we are participating providers. We will gladly file your claims to your health insurance however, we do not file automobile, general liability, homeowner's, or workman's compensation insurance. ***Initial*** _____

Financial Policies of Remedy Outpatient Clinic:

Please read and review our policies so you will understand office procedures, individual responsibilities, financial liability, and the extent and limits of various forms of communication. These policies may be updated over time for which you will be notified.

Appointments can be requested by telephone, patient portal, or email. Appointments will be confirmed by text/email ahead of time; however, it is the patient's/guardian's responsibility to keep track of the appointments to avoid charges for missed or cancelled appointments. Appointments can be cancelled by the provider if the patient is more than 10 mins late to their appointment. The patient will be subject to full charges. If an appointment is cancelled on same day or missed, the patient/guardian is subject to a no-show fee of $50.00. After 2 missed appointments within 1 calendar year, the patient will be sent a reminder of office policy. After 3 missed appointments within 1 calendar year, the patient could be dismissed from the practice. ***Initial***_____

Payment is due at the time of service. If you are unable to pay your copay, your appointment will be rescheduled and you will be billed a rescheduling fee. Failure to receive your statement does not relieve you of your financial obligations. It is your responsibility to notify us of any changes to your billing information. Past due accounts are subject to our collections process and dismissal as a patient. Other charges are as follows:

Refills: Outside of scheduled appointment	Fee: $25.00	***Initial:***
Appointment No Show and Same Day cancel	Fee: $50.00	***Initial:***
Urine Drug Screen	Fee: $10.00	***Initial:***
NSF Returned Check	Fee: $30.00	***Initial:***

Returned Phone Calls

We will return calls within 48 hours and earlier if possible. Please do not leave a message if you're in an emergency call 988 or 911. See emergency procedures below. Text messaging is ***NOT*** an acceptable form of communication. ***Initial***

_____

If for some reason you cannot reach RBH and patient/guardian deems there is an emergency, they are directed to call 911 or go to nearest emergency room for immediate services. You may also call the National Suicide Hotline at 1 800 273 8255 or 988. ***Initial***_____

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Please allow 24 hours for lab results. Our office will only call you if have abnormal readings. ***Initial***_____

Paperwork: charges are based on required time and complexity of completing forms/letters. You may be required to schedule an appointment for completion of forms/paperwork/letters. Office staff will inform you when an appointment is required. ***Initial***_____

Medications will be refilled at each appointment if it is clinically appropriate so that patient will not run out before their next appointment. If a patient runs out of medications due to a missed appointment, the non-controlled medications will be refilled one time only (if deemed clinically appropriate by the treating psychiatrist) until next available appointment. The controlled medication(s) will be refilled one time only for up to 30 days (if deemed clinically appropriate by treating psychiatrist) and an appointment must be made within the timeframe to be evaluated in person. Medication refills will not be performed in following cases: after office hours, over the weekend, during holidays, for individuals who repeatedly miss appointments, and if there is suspicion of abuse of medications. ***Initial***_____

RBH will provide services for Prior Authorizations if needed. Prior authorizations can take up to a week after provider approval to receive an approval or denial for insurance company. Patient is responsible to know if insurance requires a PA. ***Initial***_____

Risk of using Email: RBH offers patients the opportunity to communicate via a secure patient portal. We strongly encourage use of the patient portal for communication; however, you may also email RBH at intake@remedybhc.com. Do not send emails to any other email address you may come across. Transmitting patient information by unsecured e-mail has several risks that patients should consider. These include but are not limited to:
E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
E-mail senders can easily misaddress an email. ***Initial***____

Notice of Privacy:
I have been offered a copy of my Notice of Privacy Policy and have:
___ I declined a copy but am familiar with my rights and understand that I may ask for a copy at any time during my treatment.
___ I received a copy of the policy and am aware of my rights.

I, or my authorized representative hereby give consent to Remedy Behavioral Health to take my photograph. I understand this photograph will be stored in the EMR system for identification purposes and protection against insurance fraud.

Consent to provide treatment:
Remedy may provide treatment in the form of medication therapy, psychotherapy, laboratory testing, diagnostic procedures, and other appropriate alternative treatments. You have the right to: be informed of and participate in the section of the treatment methods and plan, receive a copy of this and all consents as well as request your records at any time, or withdraw any consent at any time.

Patient/guardian acknowledgement
I acknowledge that I have read and fully understand RBH *Practice Policies* above.
I acknowledge that I have read and fully understand RBH *Financial Responsibilities, HIPPA Notice of Privacy Practices, and Controlled Substances Agreement* that are available on our website or in office.
I understand the limitations of RBH availability to the client and emergency procedures.

Signature: _____ Date: _____
Print name of person Signing if not the patient: _____ Relationship: _____
Witness Signature: Date:

REMEDY

Remedy Behavioral Health, LLC
Medication list

1609 Mockingbird Ct. B
Florence AL 35630

Phone: 888 460 1290

Fax: 256 320 7776

120 South Locust St
Florence AL 35630

Patient Name: _____ DOB_____

Do you give consent to retrieve prescription history? Yes No

Medication	Dose	Directions	Medical Condition

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Adult Patient History Form

Patients Name: _____ DOB: _____

Allergies: _____

Tobacco use: nonsmoker use vape ex-smoker light smoker moderate smoker heavy smoker chews tobacco
Alcohol use: yes no
How often do you have a drink containing alcohol? never monthly 2-4 times a week 4 or more times a week
How many standard drinks containing alcohol do you have on a typical day? 0 1 or 2 3 or 4 5 or 6 7 or 9 10 or more
How often do you have 6 or more drinks on occasion? never less than monthly monthly weekly daily or almost daily

Where is patient from? _____

Describe your childhood: healthy abusive parents not together estranged foster care raised by other family members

Describe your current relationship: supportive abusive chaotic troubled satisfactory

Do you have any children: yes no Relationship is: good strained estranged

Are you satisfied with your current support system: yes no needs improvement

Job history: able to maintain work difficult to maintain work multiple jobs in last 5 years retired previous military

Occupation: _____

Substance abuse: yes no social regular use history of DUI causes problems in relationship

Past pending legal issues: _____

Past mental health treatment/counselling: none past previous IOP previous ECT

Discribe your difficulty paying for the very basics like food, housing, medical care and heating. Very hard hard somewhat hard not very hard patient declines

Education: Elementary Middle school High school GED some college Associates degree Bachelor's degree Master degree

How many days of moderate to strenuous exercise, like brisk walk, did you do in the last 7 days? _____
On those days that you engaged in moderate to strenuous exercise how many minutes on average did you exercise?

_____

Do you feel stress - tense, restless, nervous or anxious, or unable to sleep at night because your mind is troubled all the time - these days? Not at all only a little to some extent rather much very much

Marital status: married widowed divorced separated never married living with partner
In a typical week how many times do you talk on the telephone to friends, family, neighbors? _____
In a typical week how often do you get together with friends or relatives? _____
In a typical year how often do you attend church or religious services? _____

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Do you belong to any clubs organizations such as church groups, unions, fraternal or athletic groups, or school groups?
yes no
Within the last year have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
yes no
Within the last year have you been afraid of your partner or ex-partner? yes no
With in the last year have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
yes no
Within the last year have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?
yes no

Gender identity: male female transgender male/trans man/female-to-male nonbinary
transgender female/trans woman/male to female genderfluid, neither exclusively male nor female
other (please specify) _____ declines to specify

Sexual orientation? Straight or heterosexual lesbian, gay or homosexual bisexual don't know asexual pansexual
something else, please explain: _____

Family psychiatric history: _____

_____

Family history of attempted/completed suicide, relation to patient and date _____

_____

Surgical procedures: _____

_____

Mental health hospitalizations: _____

_____

Current and previous medical history: _____

_____

Current coping skills/stress relievers: faith exercise friends/family reading TV gardening relaxation housework
crafting artwork music other: _____

REMEDY

Remedy Behavioral Health

Checklist: Review of Systems

General
- Weight change
- Chills
- Fever
- Night sweats
- Fatigue

Ear/Nose/Throat
- Earache
- Hearing loss
- Ringing in ears
- Nosebleeds
- Nasal discharge
- Mouth sores
- Bleeding gums
- Hoarseness
- Throat pain

Gastrointestinal
- Appetite loss
- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Black or bloody stool

Skin
- Itching
- Skin lesions
- Rashes
- Moles of concern

Endocrine
- Excessive Sweating
- Excessive thirst
- Libido has changed
- Heat/cold intolerance
- Sensations changes

Head
- Headache
- Facial pain
- Sinus pain

Neck
- Neck pain
- Neck Stiffness
- Swelling/lump

Cardiovascular
- Chest pain
- Fast heart rate
- Palpitations
- BP drop or raise
- Swelling

Genitourinary
- Painful Urination
- Blood in urine
- Genital lesions
- Increased frequency of urination

Neurological
- Dizziness
- Vertigo
- Fainting
- Muscle weakness

Eye
- Eyesight problems
- Sensitive to light
- Eye pain
- Itching of eyes

Breast
- Breast pain
- Nipple discharge
- Breast lump

Pulmonary
- Shortness of breath
- Cough
- Coughing up blood
- Wheezing

Musculoskeletal
- Joint pain
- Joint stiffness
- Muscle aches

Other

None

Signature of patient:

REMEDY

Controlled Substance Agreement

Controlled substance medications (i.e. benzodiazepines, opioids, amphetamines are very useful, but have a high potential for misuse and are therefore closely controlled by local, state and federal government). As a patient of RBH you agree and understand the following **(initial each section)**:

____1. I agree that I will not be prescribed a benzodiazepine from RBH while on an opiate from another provider. If I am on both an opiate and benzodiazepine and would like RBH to prescribe the benzodiazepine, I agree to taper the opiate to discontinuation with the other provider. I agree to sign a release allowing RBH to communicate with the provider prescribing the opiate. If I am prescribed a benzodiazepine from RBH and prefer to be on an opiate from another provider, I agree that RBH will taper my benzodiazepine to discontinuation.

____2. Refills of controlled substance medications will not be made if "I lost my prescription", "ran out early", "misplaced my medication" or "my medication was stolen". I am solely responsible for taking the medication as prescribed and for keeping track of any remaining. Any refills for controlled substance medications that are lost or stolen will be provided at the discretion of the provider.

____3. I understand that if I violate any of the conditions of this contract, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities and the appropriate authorities

____4. I further understand that if I violate this controlled substance contract due to non-compliance of medical directions such as, failure in taking medications as prescribed, utilizing other illicit drugs or abuse of controlled medications, I may be subjected to dismissal from RBH.

____5. I agree to comply with urine drug testing. I understand that my insurance may not cover the cost of the UDS so I will be responsible for the $10.00 UDS fee. If I refuse a requested drug screen, I will not be allowed to see the provider that day and it will result in a same day cancel fee of $50.00.

____6. I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in office.

____7. I agree to not sell, share or give any medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal. I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine and other addictive substances.

___8. I agree not to obtain medication from any doctors, pharmacies or other sources without telling my treating physician. If I obtain medication from any other prescriber, my prescription for controlled medications may be terminated.

___9. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor. I understand that RBH utilizes the State of Alabama Prescription Drug Monitoring Database and will monitor my prescription history via this source.

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of RBH in regard to the controlled substance my physician is prescribing.

Patient Signature: Date:

Provider Signature: Date:

YOUR RIGHTS AND RESPONSIBILITIES

Remedy Behavioral Health, LLC
120 S. Locust Street
Florence, AL 35630
Phone (256) 320-7781 Fax (256) 320-7776
Website www.remedybhc.com

Your information. Your rights. Our responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

Your Rights: When it comes to your health information you have certain rights. This section explains your rights and some of our responsibilities to help you.

You may ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. You may ask us to contact you in a specific way (for example: home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us, you would be in danger if we do not. You may ask us not to use or share certain health information for treatment payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. You may ask for a list (an accounting) of the times we've shared your health information within the six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. You can ask for a paper copy of the notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take action. You can complain if you feel we have violated your rights by contacting our office. You can file a complaint with the U.S. Department of Health and Human Services Officer for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. Share information with your family, close friends, or other involved in payment for your care. Share information in a disaster relief situation. Contact your fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission: marketing purposes and/or sale of your information.

Our Uses and Disclosures: How do we typically use or share your information? We typically use or share your health information in the following ways. We can use your health information and share it with professionals who are treating you. We can use and disclose your information to run our organization and contact you when necessary. **We are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage.** This does not apply to long term care plans. We can use and disclose your health information as we pay for your health services. We may disclose your health information to your health plan sponsor for plan administration. We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing, or reducing a serious threat to anyone's health or safety. We can use or share your information for health research. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws. We can share health information with a coroner, medical examiner or funeral director when an individual dies. We can share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and for special government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy of security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs. ov/ocr/ rivac /hi aa/understadin /consumers/notice. .html.

REMEDY

Remedy Behavioral Health, LLC

1609 Mockingbird Ct. B
Florence AL 35630

Phone: 888 460 1290 Fax: 256 320 7776

120 South Locust St
Florence AL 35630

Authorization for the Release of Protected Health Information

This completed form authorizes and requests Remedy Behavioral Health to release the following patient's information:

Patient's Name: _____ DOB: _____ SS#: _____

I, the undersigned, authorize and request Remedy Behavioral Health to release the following **specific** patient information: (include dates of service, type of service, etc.)

☐Initial Evaluation	☐Medication List	☐Drug Screen Results	☐ Appointments
☐Financial Information	☐Lab Results	☐Diagnosis	☐EKG
☐Hospital Discharge Summary	☐Initial Evaluation		☐Drug Screen Results

Other: _____

I understand that this authorization will result in the release of clinical information regarding the patient's diagnosis, behavioral or mental health condition, substance abuse history, and psychiatric and/or counseling services. I understand that these records are strictly confidential and solely for the information of the person to whom addressed.

This information is to be released to: **(specific name and address)** _____

_____

I also authorize RBH to discuss the patient information with the above-named person and/or entity.

This information is to be released for the **specific** purpose(s) of: (if authorization requested by the patient, put "at the request of the individual") _____

This authorization is valid for one year from the date listed below. You may revoke this authorization at any time by notifying RBH in writing, but such revocation will have no effect on disclosures of information already made under this authorization prior to receipt of the revocation. This authorization is voluntary, and you may refuse to sign the authorization and the patients' treatment or payment obligations will not be affected by this authorization unless (i) the treatment is related to research and the use and/or disclosure is related to such research, or (ii) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature you may receive a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. RBH will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof until the expiration date. I hold RBH, its employees, directors, officers, agents and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.

_____ Date: _____
Patient Signature

_____ _____ Date: _____
Parent/Patient Representative Signature (If Applicable) **Printed Name and Relationship to Patient (If Applicable)**

_____ Date: _____
Witness Signature

Medicaid Insurance Waiver Form

Remedy Behavioral Health is committed to providing you with quality care. To achieve this result, we must highlight that as your provider our relationship is with you not your insurance company. While filing insurance claims is a courtesy we extend to all our patients, all charges are ultimately your responsibility. It is your responsibility to know your insurance benefits; please direct any questions concerning your coverage to your insurance company. We participate in most of Medicaid's plans however, some plans do not cover all services that we offer for example, some plans do not cover therapist visits. It is your responsibility to know what services you plan does or does not cover. Any services rendered that are not covered by Medicaid are the responsibility of the patient. Medicaid also limits patients 14 office visits a year. If you have reached your office visit limit you will be responsible for any visits going forward. If you have questions about your coverage or visit limit please contact your insurance.

I acknowledge that I have read and fully understand the terms listed above in reference to my Medicaid plan & benefits.

Signature: _____ Date: _____

Print name of person signing if not the patient: _____

Relationship: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: _____07/2021__ . ___ _____

REMEDY BEHAVIORAL HEALTH

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice explains the ways in which we may use and disclose medical information about you. It describes your rights and certain obligations we have regarding the use and disclosure of your medical information. The law requires us to (1) Ensure your medical information is protected; (2) Provide you with this Notice describing our legal duties and privacy practices with respect to medical information about you; (3) Follow the current terms of the Notice in effect.

WAYS WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information however, will fall within one of the following categories.

Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Our office shall abide by all applicable state and federal laws related to the protection of this information.

1. Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other personnel who are involved in your care. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may also share medical information about you with our office personnel or other providers, agencies or facilities in order to provide or coordinate such things as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside our office who may be involved in your continuing medical care after you leave our office such as other health care providers, transport companies, community agencies and family members.

2. Payment. We may use and disclose medical information about the treatment and services you receive at our office so that payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about treatment you received at our office so your health plan will pay us or reimburse you. We may also tell your health plan about a proposed treatment in order to obtain prior approval or to determine whether your plan will cover the treatment.

3. Health Care Operations. We may use and disclose medical information about you to support our office operations. These uses and disclosures are made to improve our quality of care. Your medical information may also be used or disclosed to comply with laws and regulations, for contractual obligations, patient's claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration or the sale of all or part of our office to another entity, underwriting and other insurance activities. For example, we may review medical information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians and other personnel for performance improvement and educational purposes.

4. Appointment Reminders. We may contact you to remind you that you have an appointment at our office.

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

6. Health-Related Benefits and Services. We may contact you to tell you about benefits or services that we provide.

7. Others Involved in Your Care. We may release medical information to anyone involved in your medical care. For example: a friend, family member, personal representative or an individual you identify. We may give information to someone who helps pay for your care or we may tell your family or friends about your general condition.

8. Research. Your medical information may be important to further research efforts. We may use and disclose your medical information for research purposes, subject to the confidentiality provisions of state and federal law.

9. As Required By Law. We will disclose medical information about you when required to do so by federal or state law, if asked to do so by law enforcement in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process; or for intelligence, counterintelligence, and other national security activities authorized or required by law.

10. To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you for public health purposes or when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat

11. Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

12. Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although the medical information we obtain about you is the property of our office, you do have the following rights:

1. **Inspect and Copy**. With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing information. To inspect and/or to receive a copy of your information, you must submit your request in writing to our **Office Manager**. If you request a copy of the information, we may charge a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by our office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
2. **Request an Amendment or Addendum.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or our office. To request an amendment, your request must be made in writing and submitted to our **Office Manager**. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it 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: was not created by our office, is not part of the medical information kept by or for our office, is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete in the record. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.
3. **Accounting of Disclosures**. You have the right to receive a list of the disclosures we have made of medical information about you that were for purposes other than treatment, payment, health care operations and certain other purposes. To request this accounting of disclosures, you must submit your request in writing to our **Office Manager**. Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, we may charge you for the cost of compiling the accounting. 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.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical 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 medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. ***We are not required to agree to your request.*** If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our **Office Manager.** In your request, you must tell us (1) what information you want to limit (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example: disclosures to your spouse.
5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our **Office Manager**. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
6. **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 this Notice electronically you are still entitled to a paper copy of this Notice.

CHANGES TO OUR PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our office's privacy practices and this Notice. We reserve the right 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 a copy of the current Notice at our office. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our **Office Manager**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.