Alexander Chiropractic Center

22930 Three Notch Rd, California, MD 20619 * 301-737-4007
14350 Solomons Island Rd, Suite 103A, Solomons, MD 20688-1269 * 410-394-1000

Confidential Health Questionnaire

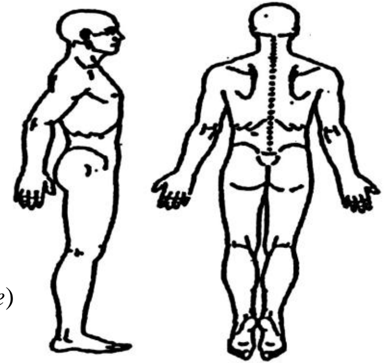
Patient Name: _______________________________ **Date of Birth:** ______________ **Date**: _____________

Present Complaint(s): ____

1. Have you ever been in an automobile accident? □ No □ Yes, when____

2. Have you ever been injured at work? □ No □ Yes, when____

3. Indicate on the drawings below where you have pain/symptoms:



4. Please select all that apply: □Sharp □Dull □Achy □Burning □Stiff
□Numbness □Shooting □Tingly □Radiating □Soreness □Stabbing □Other
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. Intensity of your symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) (*Please circle*)

6. How do you think your problem began?____

7. How long have you had this problem? ___________ days _________ months ________ years

8. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

9. What aggravates your problem?____

10. What alleviates your problem?____

11. Have you had this problem before? ____

12. How much has the problem interfered with your work?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

13. How much has the problem interfered with your sleep?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

14. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

15. This problem prevents me from:____

16. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician □ No one
□ ER physician □ Orthopedist □ Physical Therapist □ Other: _____________

17. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What level of exercise do you do? □ Strenuous □ Moderate □ Light □ None

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash/skin condition/acne
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ STD'S
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Thyroid Problems
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Excessive Fatigue
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Unusual Hair Growth
□	□ Arthritis	□	□ Hepatitis	□	□ Hair Loss
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Inability to Loose/Gain Weight
□	□ Cancer	□	□ General Fatigue	□	□ Excessive Mood Swings
□	□ Tumor	□	□ Muscular In coordination	□	□ Hot Flashes or Night Sweats
□	□ Asthma	□	□ Visual Disturbances	□	□ Mental Fog
□	□ Chronic Sinusitis	□	□ Dizziness / Mental Fog		
□	□ Other:___________________________				

For Females ONLY:

Past	Present	Past	Present	Past	Present
□	□ Birth Control Pills	□	□ Hormonal Replacement	□	□ Pregnancy ______weeks
□	□ Heavy/painful Menstrual Cycle	□	□ Irregular Menstrual Cycle		

20. Have you ever had any surgery: □ No □ Yes ____

21. Have you ever been hospitalized? □ No □ Yes, why____

22. Have you had significant past trauma? □ No □ Yes

23. Indicate if you have any immediate family members with any of the following: □ Stroke □ High Blood Pressure □ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

24. Anything else pertinent to your visit today? ____

Print Name: ______________________________________

Patient / Guardian Signature:___________________________ Date:___________________

Alexander Chiropractic Center

14350 Solomons Island Rd Suite 103A
Solomons, MD 20688-1269
Phone: 410-394-1000

22930 Three Notch Rd
California, MD 20619
Phone: 301-737-4007

PLEASE PRINT ALL INFORMATION **_Patient Information_**

First Name: ____________________ Last Name: ___________________MI: ___ Preferred Name:________________

Date of Birth: ____/_____/____ AGE: __________ SSN: ___-__-______ ( ) Male ( ) Female

Address: ____ Apt. #: __________

City: ____ State: __________ Zip Code: __________

Phone Numbers: ( ) ____________________ (Home) ( ) ____________________ (Work) ( ) ____________________ (Cell)

May we leave a voicemail regarding future appointments including date and time? Initials: __________

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Emergency Contact: ______________________ Relationship: ___________ Contact Phone:____________________

Do we have permission to speak with this person regarding appointment days and times? Initials: _________

Primary Care Dr.: ___________________ & Phone: _________________

How were you Referred: ____________________; if by a patient what is the patient's name: ____________________

Health Insurance Information: (Please complete if you have insurance.)

Primary Health Insurance:

Company: ___________________ PPO / HMO / Fed / EMO / POS Insured Name: ____________________

Relationship to patient: Self / Spouse / Child / Other ___________ Insured DOB: ______________________

Policy #: ____________________ Group #: ____________________ Insured SSN: _____________________

Claim #: ____________________ Insurance Phone: ______________ Insured Employer: ________________

Secondary Health Insurance:

Company: ___________________ PPO / HMO / Fed / EMO / POS Insured Name: ____________________

Relationship to patient: Self / Spouse / Child / Other ___________ Insured DOB: ______________________

Policy #: ____________________ Group #: ____________________ Insured SSN: _____________________

Claim #: ____________________ Insurance Phone: ______________ Insured Employer: ________________

Please Read *Before* Signing – Signature on File Statement.

I hereby give my permission to the doctor to perform such procedures and administer treatment as he may deem medically / chiropractically necessary in the diagnosis and / or treatment of my condition. I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize payment directly to **Alexander Chiropractic Center**. I permit a copy of this authorization to be used in place of the original. I understand that my insurance coverage is a contract between my insurance co. and myself and that **Alexander Chiropractic Center** will submit claims on my behalf but will not be responsible for filing appeals or disputing rejections. I agree with the above requirements and request that **Alexander Chiropractic Center** submit claims on my behalf. I understand that I am responsible for all charges incurred regardless of my insurance status. I understand that there will be a $25.00 fee for all returned checks.

______________________________ Patient Signature

______________________________ Parent / Guardian Signature

______________ Today's Date

Alexander Chiropractic Center

14350 Solomons Island Road, Suite 103A
Solomons, Maryland 20688-1269
Phone: 410-394-1000
Fax: 410-394-6800

22930 Three Notch Road
California, MD 20619
Phone: 301-737-4007
Fax: 301-737-4003

Authorization To Pay Physician

I, ______________________________, hereby authorize the ______________________________ insurance company to pay by check made out and mailed directly to:

Alexander Chiropractic Center
PO Box 1269
Solomons, Maryland 20688

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, the balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, I authorize you to make the check out to me and mail it as follows:

____
C/O Alexander Chiropractic Center
PO Box 1269
Solomons, Maryland 20688

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that ultimately I am financially responsible for all services rendered to me.

I hereby give my permission to **Alexander Chiropractic Center** to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby give my permission to **Alexander Chiropractic Center** to file formal grievances with the Maryland Insurance Commissioner when necessary on my behalf, should my insurance company deny payment of all or part of my medical bills.

____
Patient / Guardian Signature

____
Today's Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:___________________________ **Last Name**:___________________________

Email address: __________________@__________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text

DOB: ___/___/_____ Gender: ( ) Male ( ) Female

Your Employer:_________________________________ Occupation: __________________

Employers Address: ____

Preferred Language: _____________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

***If more than 3 medications, please continue list on back of page**

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:________________

For office use only

Height_________ Weight_________ Temp_________ Blood Pressure:______/______ Pulse __________

History of : Diabetes_____ Cancer______ High Blood Pressure_____ Pregnancy_____

Metal Implants _____ Pacemaker _____ Initials _________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received ALEXANDER CHIROPRACTIC CENTER'S Notice of Privacy Practices for protected health information.

Date: ____________________ Name of Patient: ____________________________________
Print Name

____
Signature of Patient/Personal Representative

Alexander Chiropractic Center
Notice of Privacy Practices

September 1, 2013

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

PLEASE REVIEW THIS NOTICE CAREFULLY.
If you have any questions about this notice, please contact our privacy officer: Kim or Penny, P.O. Box 1269, Solomons, MD 20688
410-394-1000 or 301-737-4007

1 .**Summary of Rights and Obligations Concerning Health Information**
Alexander Chiropractic Center is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law, as well as by ethics of the medical profession. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Alexander Chiropractic Center.

Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have certain rights to your health information. You have the right to:

* ensure the accuracy of your health record;
* request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
* request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices,* as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices;*
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.

Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised *Notice of Privacy Practice*s will be distributed to the extent required by law.

We will not use or disclose your health information without your authorization, except as descried in our most current *Notice of Privacy Practice*s.
In the following pages we explain our privacy practices and your rights to your health information in more detail.

2. **We May Use or Disclose Your Medical Information In the following Ways**
A. ***Treatment.*** We may use and disclose your medical information to provide you with medical treatment or services. For example, we may use your health information to write a prescription or to prescribe a course of treatment. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your

treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

B. ***Paymen***t. We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

C. ***Health Care Operations***. We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

E. ***Business Associates***. [Name of provider] sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

F. ***Appointment Reminders***. We may use and disclose information in your medical record to contact you as a reminder that you have an appointment at (name of provider). We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

G. ***Treatment Options***. We may use and disclose your health information in order to inform you of alternative treatments.

H. ***Release to Family/Friends***. Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

I. *Health-Related Benefits and Services.* The following sentence is required only if the practice intends to send information to patients concerning health-related benefits or services. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face-to-face communications, such as appointments with your physician, we may tell you about other products and services that may be of interest to you.

J. ***Newsletters and Other Communications***. We may use your personal information I order to communicate to you via newsletters, mailing, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

K. ***Disaster Relief.*** We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

L. ***Marketing.*** In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

N. ***Public Health Activities***. We may disclose medical information about you for public health activities. These activities generally include the following:

* Licensing and certification carried out by public health authorities;
* Prevention or control of disease, injury, or disability;
* Reports of births and deaths;
* Reports of child abuse or neglect;
* Notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
* Organ or tissue donations; and

* Notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.

O. ***Funeral Directors***. We may disclose health information to funeral directors so that they may carry out their duties.

P. ***Food and Drug Administration (FDA).*** We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

Q. ***Psychotherapy Notes***. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.

R. ***Research.*** We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

S. ***Workers Compensation***. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

T. ***Law Enforcement***. We may release your health information:

* in response to a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law;
* to identify or locate a suspect, fugitive, material witness, or similar person;
* about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
* about a death we believe may be the result of criminal conduct:
* about criminal conduct as (name of provider);
* to coroners or medical examiners;
* in emergency circumstances to repost a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
* to authorized federal officials for intelligence, counterintelligence, and other
* national security authorized by law; and
* to authorized federal officials as they may conduct special investigations or provide protection to the President, other authorized person, or foreign heads of state.

U. ***De-identified Information.*** We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

V. ***Personal Representative.*** If you have personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

W. ***HLTV-III Test***. If we perform the HLTV_III test o you (to determine if you have been exposed to HIV), we will not disclose the results of the test to anyone but you without your written consent unless otherwise required by law. We also will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

X. ***Limited Data Set***. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research public health, and health care operations. We may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposed for which it was provided, ensure the security of the data, and not identify the information or use it to contact nay individual.

3. **Authorization for Other Uses of Medical Information**
Uses of medical information not covered by our most current Notice of Privacy Practices or the laws that apply to us will be made only with your written authorization.

If you provide us with authorization to use or disclose medical 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 medical information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was

obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

4. **Your Health Information Rights**
You have the following rights regarding medical information we gather about you:

A. ***Right to Obtain a Paper Copy of This Notice***. You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

B. ***Right to Inspect and Copy***. You have the right to inspect and copy medical information that may be used to make decisions about your care.

Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the social Security Act (such as claims for Social Security, supplemental Security Income, and MassHealth benefits) or any other state or federal needs-based benefit program.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

C. ***Right to Amend.*** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.

To request an amendment, your request must be made in writing and submitted to our privacy officer. 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 us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for (name of provider);
- is not part of the information which you would be permitted to inspect and copy; -or-
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement.

We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

D. ***Right to an Accounting of Disclosures.*** You have the right to request an accounting of disclosure of your health information made by us. In your accounting, we are not required to list certain disclosures, including:
* disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
* disclosures made pursuant to your authorization;
* disclosures made to create a limited data set;
* disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer that six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosure 9for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at the time, before

any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

E. ***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. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we are required to honor that request.

You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.

Except as noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply.

F. ***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 e-mail.

To request confidential communications, you must make your request in writing to our privacy officer. 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.

G. ***Right to Receive Notice of a Breach***. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U. S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address,

Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more that 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

5. **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U. S. Department of Health and Human Service, 200 Independence Ave., S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for civil Rights website, www.hhs.gov/oct/hipaa/ for more information. You will not be penalized for filing a complaint.