



New Patient Demographics

Patient Information

Last Name: First Name: MI: Suffix:

Date of Birth: Social Security: Marital Status:

Address: City: State: Zip:

Home Phone: Cell Phone: Email:

Race: Ethnicity: Language: Gender: Male Female

Emergency Contact: Relationship: Phone:

Summer Winter Add: City: State: Zip:

Financial Information

Responsible Person: Relation: DOB:

Insurance Name: Subscriber ID:

Specialist Co-Pay: Payer ID:

Secondary Insurance: Secondary ID:

Primary Care Physician (PCP): Phone:

Referring Provider (if other than PCP): Phone:

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lake Endocrinology and Diabetes, PLLC, and any assisting providers for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or Legal Guardian Printed Name:

Signature: Date:



Lake Endocrinology and Diabetes

Review of Systems

PATIENT INFO:

Last Name: _____ First Name: _____ Date of Birth: _____

Review of Systems: Please check/circle the problems you are currently experiencing:

- | | | | |
|---|---|---|--|
| GENERAL
<input type="checkbox"/> Extreme fatigue
<input type="checkbox"/> Fever
<input type="checkbox"/> Weight Gain/Loss

EYES
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Bulging Eyes
<input type="checkbox"/> Dry Eyes

NECK/Thyroid
<input type="checkbox"/> Enlargement
<input type="checkbox"/> Thyroid nodules
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Change in voice

RESPIRATORY Wheezing
<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Shortness of breath

HEME/ONC
<input type="checkbox"/> History of Cancer
<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> New/Growing lump | CARDIOVASCULAR
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Swelling legs
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Heart Racing
<input type="checkbox"/> High blood pressure

GASTROINTESTINAL
<input type="checkbox"/> Nauseas/vomiting
<input type="checkbox"/> Diarrhea/
constipation
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Feeling full early
<input type="checkbox"/> Frequent urination

GYN/BREAST
<input type="checkbox"/> Irregular Menstrual
<input type="checkbox"/> Breast Pain
<input type="checkbox"/> Nipple Discharge | GENITOURINARY
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Very thirsty
<input type="checkbox"/> Erectile
dysfunction
<input type="checkbox"/> Prostate
enlargement
<input type="checkbox"/> Abnormal cycles
<input type="checkbox"/> Poor sex drive

NEUROLOGICAL
<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizzy upon standing
<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Loss of
consciousness

ENDOCRINE
<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Very thirsty
<input type="checkbox"/> Very hungry
<input type="checkbox"/> Weight loss
<input type="checkbox"/> Weight gain
<input type="checkbox"/> Increased urination | INFECTIOUS DISEASE
<input type="checkbox"/> Fever

MUSCULOSKELETAL
<input type="checkbox"/> Bone pain
<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Pain or cramping
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Hip area symptoms

MENTAL HEALTH
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Severe Depression

SKIN
<input type="checkbox"/> Rash
<input type="checkbox"/> Wide purple
stretch marks
<input type="checkbox"/> Skin Tags
<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Increased dark
hair
<input type="checkbox"/> Sores will not heal |
|---|---|---|--|

Medication List: Please list current medications, over-the-counter meds, vitamins, & supplements:

Medication Name	Dose (mg)	Frequency Day/Week		Medication Name	Dose: (mg)	Frequency Day/Week



Lake Endocrinology and Diabetes

Review of Systems Continued

Past Medical History: Please check all the diagnoses you have a history of:

- | | | |
|---|--|--|
| <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Type 2 Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Thyroid Nodules | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Hyperthyroidism (overactive) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hypothyroidism (underactive) | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Thyroid Cancer | <input type="checkbox"/> Lung Disease | |

Allergies: Please list medication allergies and your reaction to them:

Medication Name	Reaction

Surgical History: Please list surgeries you have had and what year:

Name of Surgery	Date	Name of Surgery	Date

Hospitalizations: Please list the reason and date for any hospitalizations:

Reason	Date	Reason	Date

Family History: Please list any medical problems your immediate family members have /had.

Immediate Family:	List diagnoses or medical problems:	Age at Death:
Father		
Mother		
Brother(s)		
Sister(s)		
Child/Children		
Paternal Grandparents		
Maternal Grandparents		

Social History: Please complete the following:

Marital Status:	Married Widow Single Divorced Partner Other:				
Do you smoke?	Yes	No	Packs per day:	Quit Date:	
Do you drink?	Yes	No	Drinks per week:	Type:	
Do you use drugs?	Yes	No	Frequency:	Type:	
Do you Exercise?	Yes	No	Times per week:	Type:	



Formulary Benefits Data Consent Form

Formulary Benefits Data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for Lake Endocrinology and Diabetes to access my pharmacy benefits data electronically through RxHub. This consent will enable Lake Endocrinology and Diabetes to:

- ❖ Determine the pharmacy benefits and drug copays for the patient's health plan.
- ❖ Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- ❖ Display therapeutic alternatives with preference rank (if available) within drug class for non- formulary medications.
- ❖ Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- ❖ Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

PRINT Patient Name

Date of Birth

Signature of Patient/Guardian

Date

Brian M. Lake, DO and Kimberley Philip, APRN
13123 66th Street Largo, FL 33773
Phone: 727-477-1039 Fax: 727-477-0498



Lake Endocrinology and Diabetes RECORDS REQUEST

PATIENT INFORMATION:

Patient Last Name: _____ Patient First Name: _____ Date of Birth: _____ Phone: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM:

Doctor: _____ Fax: _____ Phone: _____

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

Additional Doctors, Hospitals, or Facility: _____ Fax: _____ Phone: _____

PLEASE SEND MY MEDICAL RECORDS TO:

___ Dr. Brian Lake NPI:1295887040 Group NPI:1619418563 Kimberley Philip, APRN NPI 1538130919

Address: 13123 66th Street Largo, FL 33773

Phone: 727-477-1039

Fax: 727-477-0498

FOR THE FOLLOWING REASON(S):

___ Specialist Care ___ Consult/Second Opinion ___ Moving out of Area ___ Personal Information ___ Legal ___ Transfer of Care

___ Other: _____

MEDICAL HEALTH INFORMATION AND DOCUMENTS TO BE DISCLOSED:

___ Office Notes and Reports (Last 3 Visits) ___ Radiology/Diagnostic Reports ___ Lab Reports ___ Hospital Records ___ Billing

___ Previous Endocrinology Notes (1 year) ___ Other (Please list) _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING SENSITIVE PROTECTED HEALTH INFORMATION:

HIV/AIDS/HBV,TB, or other Communicable Diseases ___ Yes ___ No Domestic Violence: ___ Yes ___ No

Mental Health Information and Records ___ Yes ___ No Drug/Alcohol Information: ___ Yes ___ No

Genetic Testing Information and records ___ Yes ___ No

Notice, Consent, and Authorization:**Please allow 10 days for processing. Incomplete information will delay the processing.****By signing below, I understand that I may be charged for copies.**

I authorize records can be sent or received by unencrypted email which can be less secure than portal, direct upload, fax, or mail. Approved email: Info@lakeendocrine.com, Use of this information for any other reason than the stated purpose is prohibited. This information is for the designated recipient only and cannot be provided to another agency. If received in error, please notify the sender by phone at 727-477-1039. **This authorization has no expiration unless I have listed the expiration date as: ___/___/___.** I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I sign this authorization. It may be revoked at any time upon written notification by the signatory or patient, but revocation has no effect on action previously taken.

I understand that, IF the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality Requirements.

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric testing, physical abuse, or drug and alcohol abuse. This information is being released, received, and used for the purposes of coordinating my care, evaluating my needs and providing services to me.

SIGNATURE of PATIENT or Representative: _____ **Date:** _____**PRINT Representative Name if not patient:** _____ **Relationship:** _____

Please contact our office if you have any questions or concerns at Phone: 727-477-1039.



OFFICE POLICIES

Welcome to the offices of Brian Lake, D.O, and Kimberley Philip, APRN of Lake Endocrinology and Diabetes, PLLC. In order to provide our patients with the best quality of care in a compassionate and timely manner, we have established these policies. Please feel free to contact our office if you have any questions. We look forward to establishing and maintaining a positive relationship while improving your health.

- **Office Hours:** Monday – Thursday 8:00a.m.- 5:00p.m., Fridays 8:00am to 12:00pm. We are closed for lunch and to complete paperwork or return phone calls between 12:00pm and 1:00pm daily. Subject to change.
- **Emergencies:** For medical emergencies please dial 911. The physician will be on call 24/7 for emergencies. All non-emergencies will be directed to wait until the next business day. If you need to see the doctor the same day, ask for an urgent/same day appointment. If one is available, you may be scheduled. If not, you may need approval from the nurse or the physician or may be directed to the nearest urgent care or emergency room.
- **Scheduling appointments:** You may call the office to schedule. Because we offer quality and compassionate care, our next available new patient appointment may be in 3-4 months from the time you call. Your physician may request an urgent appointment by contacting Dr. Lake. Completing new patient paperwork thoroughly and quickly will help us to obtain your records, referrals, medication list, and prep your chart for your visit.
- **Wait-List:** We offer a wait-list to anyone who would like a sooner appointment and has completed their new patient paperwork. In the event someone cancels or reschedules, we will offer that appointment to patients on our wait-list. Priority will be given to those who are urgent, symptomatic, available, and have records on file.
- **Office Visits:** Office visits are made by appointment only. Dr. Lake prides himself on giving quality care and being on-time. We do not double book appointments. Therefore, we ask that you also arrive in a timely manner:
 - **New Patients:** Please check in ON TIME. Check-in time will be the same time as the appointment time and your reminders. We need ample time to provide quality care.
 - **Follow up appointments:** Please arrive a few minutes early to check-in and confirm insurance, demographic, Payment, and HIPAA information with the receptionist.
 - **All Patients:** Please have your insurance card, ID, co-payment, referral, records, glucose meter or log book, sensor and insulin pump ready (if applicable) for check-in.
 - **Virtual visits/Telemedicine:** May be available during pandemics or other unforeseen natural disasters. These appointments must be pre-approved by the physician. Please call to arrange ahead of time.
 - **Late Arrivals:** Reasonable requests will be accommodated, time and availability permitting. However, if you will be late, please call. No-Show, same day cancellations, or late arrivals may be subject to fees.
- **No-Shows/Same Day Cancellations/Late Arrivals:** We understand emergencies happen. If you are unable to keep a scheduled appointment, please call our office at least 24 hours in advance so we can reschedule free of charge, and accommodate another patient off of the wait-list. We do not double book appointments and want to maintain your health. A \$35 fee applies to Established patients appointments broken with less than 24-hour business notice, No-Shows, or late arrivals unable to be accommodated. Established Patients may be discharged after three occurrences. A\$75 fee applies to New Patients appointments broken with less than 24-hour business notice, No-Show, or arrived too late to be accommodated and will not be rescheduled without prior approval from the physician.
- **Phone Calls:** If we are with patients and unable to answer, please leave your detailed message and phone number and someone will return your call same day or within 24 business hours.



OFFICE POLICIES

Continued

- **Medical Records:** Dr. Lake reviews your labs, radiology, and records prior to your visit. Please complete our records request for your PCP and/or previous Endocrinologist or referring doctor or contact their office to request your records. Many offices require 10 days to complete records request. You may be automatically be opted in to the Interoperability Hub through a records network such as Commonwell or Carequality to allow patient health data exchange between your doctors and hospitals. You may opt out by contacting our office in writing. We also fax your office note to your primary care and referring physician on file, please notify us when you change your pcp or referring physician.
- **Records Requests:** Patient records are provided free of charge to the patient and available 24/7 on the patient portal. If you need a copy of your medical records, please complete and sign the appropriate paperwork so we can release them. A copying charge of up to **\$1.00** per page plus postage and fess or other fees will apply to additional or third party requests according to the Florida Administrative Code or **\$50.00** per chart. Requests will be sent same day when possible but may take up to 10 days or sent when payment is received.
- **Referrals:** If you have a managed care insurance plan or HMO, your insurance requires a referral authorization to see a specialist. We will make every reasonable effort to obtain these authorizations from your primary care provider (PCP) on your behalf. You or your PCP must request a referral authorization from your insurance and send it to us. This may take 5-10 business days. Appointments without authorized referrals will be denied by your insurance, canceled by our office, and /or rescheduled until proper authorization is received.
- **Ultrasounds and Biopsies:** Ultrasounds and Biopsies can be scheduled for established patients. We are happy to obtain a pre-authorization for these procedures if your insurance requires one. Please make sure it is covered and authorized. You agree to pay any additional insurance diagnostic copays, deductibles, or coinsurance.
- **Coordinated Care:** We send our office notes to your primary care physician (PCP) and other specialists that you see for the best coordinated care possible. We also request that they do the same and forward your labs, office notes, and radiology to us. Please let our office know if any of your other physicians have changed.
- **Nondiscrimination and Accessibility:** We comply with applicable Federal Civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, or sexual orientation. If you need an interpreter, or paperwork in another language, or accommodations, please notify the office.
- **Prescriptions and DME:** If you need a refill, please contact your pharmacy and allow 72 business hours for your request to be completed. The doctor does not call in prescriptions after business hours, and for safety reasons may not be able to renew your prescription until you have been seen. If you haven't seen the doctor recently, you may need to make an appointment to review your medical history and make any necessary changes before prescriptions or durable medical equipment (DME) can be refilled. Some prescriptions and DME require prior authorization from your insurance company and this may take up to a week, so please call well in advance of your needs. Always provide the name of the medication, dosage, 30 or 90 day supply requested, and the pharmacy used when calling the office.
- **Patient Conduct:** We give professional and respectful care and expect the same in return. Patients who disrupt the office, abuse, harass, break office policies, the Florida Patient's Bill of Rights and Responsibilities, and or yell at staff will be dismissed from the practice. Please address concerns and compliments with manager.

Brian M. Lake, DO and Kimberley Philip, APRN

Address: 13123 66th St. Largo, FL 33773 Phone: 727-477-1039 Fax: 727-477-0498



OFFICE POLICIES
Continued

- **Forms:** We ask for 72 business hours for forms to be completed at no charge. A current office visit may be required.
- **Medical Students:** From time to time, the doctor may have medical residents or students who are in training working with him. If you do not wish to have one of these students or residents see you, please let us know in advance.
- **Nurse Practitioner:** We have added our Nurse Practitioner (APRN) to better serve your needs and to alleviate wait times for new patient appointments. Dr. Lake will coordinate care with the nurse practitioner. Follow up appointments can alternate between the Physician and the nurse practitioner for continuity of care.
- **Financial Responsibility:** The patient or patient's guardian is responsible for payment of all services rendered by our physicians/providers. Please speak to the office manager to set up payment plans prior to services.
- **Payment and Card on File:** Payment in cash, check, or credit card is expected at the time of service unless other arrangements are made in advance. We accept most major credit cards. A Card and/or Signature on file is required and authorized to pay balances not paid by insurance within 90 days and not to exceed services rendered.
- **Co-Payments:** All insurance co-payments, deductibles, and co-insurances are due at the time of the office visit prior to seeing the doctor. According to your insurance contract, we are unable to bill for co-payments.
- **Insurance:** We file claims to insurances with which we have a contract. Please check with your insurance company, or with us prior to seeing the doctor to make sure we accept your plan. Claims for any other insurance companies with which we are not contracted must be filed by you. After you pay us, we will provide you with the receipt you will need to send to your insurance company. Request a Good Faith Estimate (GFE) to see the fees you will be responsible for or that will be applied to your OON benefits or self pay accounts. For In Network Insurances, you are responsible for paying the full balance due of any co-pays, deductibles, co-insurance, denied, or non-covered services according to your insurance benefits in a timely fashion.
- **Delinquent Accounts:** If you fail to pay your bill or the bill of anyone for which you are financially responsible (such as a child or spouse), routine appointments will be held until the matter is resolved. There is a fee of \$25 for all checks returned to us due to insufficient funds or other non-payment by your bank. Balances not paid after 3 statements or 90 days will be referred to a collections agency. You will then be responsible for a \$40.00 fee and any costs incurred from that agency, in addition to the amount you owe us and dismissed from the practice. Allowing this to happen may affect your personal credit. If we take you to court because of an unpaid balance, you are responsible for any and all costs incurred, including, but not limited to, lawyer's fees and legal filing fees.
- **Living wills and Powers of Attorney:** Please inform the receptionist if you have living wills or powers of attorney that pertain to your care. We will need copy to put into your chart.

I have read the above office policies. I understand them and I agree to them as a condition for being seen by my doctor.

Patient's Printed Name

Date of Birth

Patient's Signature

Date



Patient Portal Authorization

1. Purpose

The purpose of the Patient Portal Consent Form is to get consent from patients who will use the Patient Portal with given credentials in order to access, view and monitor their medical conditions.

It is intended to present possible risks, benefits and conditions of the Patient Portal to patients with this Patient Portal Consent Form.

2. Patient Portal

Patient Portal is a web portal which allows patients to view and reach their medical records which are lab results, medical history and medications. The patient can access the secure Patient Portal via the internet.

3. Confidentiality

Medical and personal information of the patient are protected by the state and federal laws. The patient can access the Patient Portal via his or her credentials and it is the patient's responsibility to protect the credentials from unauthorized people, services or organizations.

4. Risks

The medical information, personal information and communication channels in the Patient Portal are protected securely. However, the patient needs to be careful while using the portal. The patient should be sure that the message is sent to the correct email address.

If the patient thinks that the credentials are stolen, he or she needs to notify the Healthcare Center immediately.

Patient Name _____ DOB _____

Personal Email: _____ (Personal recommended)

I have been informed about the potential risks, benefits and confidentiality of the Patient Portal. I acknowledge that the information I have given is accurate and complete. By signing below, I, as a patient or a representative, accept all the terms & conditions and I accept that I am the responsible party for protecting my credentials that are used to access the Patient Portal. I have fully understood the policies and wish to participate in the Patient Portal.

Patient Signature: _____ Date: _____



HIPAA PRIVACY ACT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not the patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have received our Privacy Notice (Confidentiality of Patient Medical Records) and have the right to review it, to request restrictions, and to revoke consent in writing.

Please list Family Members or Persons to whom you want Medical Information disclosed to:

Name of person

Relation to you (*ex. Spouse/Mother*)

Name of person

Relation to you

Print PATIENT Name

Date of Birth

Signature

Date

Brian M. Lake, DO and Kimberley Philip, APRN
13123 66th Street Largo, FL 33773 Phone:
727-477-1039 Fax: 727-477-0498

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

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ **See page 3** for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

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.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record 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 information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is 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.

Request confidential communications

- You can 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 say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can 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.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for 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’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- 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 any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office 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.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- 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
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- 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 law.
-

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.
-

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers’ compensation, law enforcement, and other government requests

- We can use or 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
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
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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 or 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.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.