Alabama Bariatrics and Minimally Invasive Surgery, P.C.

Decatur • Huntsville

P: 256.274.4523 F: 256.203.8791

W. Jay Suggs, M.D. FACS, FASMBS / Andrew Harner, M.D.

Patient's Name:_____

Birth Date: _____Social Security Number:_____

Mailing Address:_____

City: _____State:____Zip code:_____ Cell Number:_____

Home Number:_____Email:_____

Employer:_____ Work Phone:_____

Employer Address:_____City:_____State:____ Zip:_____

Referring Physician:_____ Phone #:_____

Pharmacy Information

Pharmacy Name:_____ City:_____ State:____

Phone Number:_____

Emergency Contact

Name:_____ Relationship_____

Home Number:_____ Work Number:_____ Cell Number:_____

Insurance Information

Primary Insurance Information: Plan Name:_____Copayment:$_____

ID #:_____ Group#:_____

Name of Insured:_____Relationship to patient:_____

Insured's D.O.B._____ Insured's SSN:_____

Secondary Insurance Information: Plan Name:_____Co-payment: $_____

ID #:_____ Group#:_____

Name of Insured:_____Relationship to patient:_____

Insured's D.O.B._____ Insured's SSN:_____

I hereby assign, transfer, and set over to Alabama Bariatrics and Minimally Invasive Surgery, P.C. all rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If this account is submitted to collections, I, the undersigned, agree to any and all collection costs and reasonable attorney fees. Returned checks will incur a $35 fee. Please call 24 hours in advance to cancel your appointment.

Patient Signature:_____ Date:_____

Alabama Bariatrics

Surgery & Procedure Cancellation/No-show Fee Consent

Bariatric surgery:

Surgery must be cancelled at least **5 days** before the date of scheduled surgery. Surgery must also be performed within **1 year** of the approval date. If you cancel or no show in under 5 days of the scheduled surgery date, or if you have expired your approval, you will be responsible for a **$500.00** surgery cancellation/no-show fee.

Fluoroscopic band adjustments:

Scheduled fluoroscopic band adjustments must be cancelled/rescheduled at least **3 days/72 hours prior** to your scheduled date. If you fail to cancel or reschedule before that time, you will be responsible for a **$125.00** cancellation/no-show fee.

EGD:

Scheduled EGD's must be cancelled/rescheduled at least **3 days/72 hours prior** to your scheduled date. If you fail to cancel or reschedule before that time, you will be responsible for a **$125.00** cancellation/no show fee.

Why do we do this? ...When patients cancel and no-show at the last minute, this delays others that have been waiting patiently from getting scheduled in a timely manner. We do this to help YOU be able to get your procedure and surgery as soon as we possibly can!

Patient signature:_____ Date:_____

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NON-COVERED SERVICES WAIVER

Patient Name (PLEASE PRINT):_____

Date of Service:_____

Insurance:_____

I understand that my insurance company may or may not cover services provided to me today. This may include an office visit. I also understand that none of my diagnoses will be changed to satisfy insurance requirements. I understand that I am fully responsible for any charges that my insurance company does not cover for whatever reason. Should I proceed forward with surgery, I understand it is my responsibility to pay the $125 program fee that is not covered by insurance. Any charges denied by my insurance company prior to my surgery or procedure must be paid in full. If not, I understand that my surgery or procedure will be postponed until my financial obligations are met.

Physician Ownership Disclosure:

Federal regulation also requires physicians to advise patients if they have ownership interest in facilities. Currently, Dr. Suggs owns shares of Decatur Ambulatory Surgery Center.

Email/Text message agreement:

☐ I give Alabama Bariatrics permission to share my private medical information with me via text message, phone, and/or email.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

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W. Jay Suggs, M.D. FACS, FASMBS / Andrew Harner, M.D.

Authorization for release of medical documentation

Date: _____

Permission is hereby given to: _____
(Physician Name)

_____
(Street Address)

_____
(City) (State) (Zip code)

_____
(Phone Number) (Fax Number)

For the release of the following information contained in the medical records of:

Patient Name: _____

Address: _____

City:_____State:_____ Zip code:_____

D.O.B.:_____ S S Number:_____

__Weight Loss Progress Note __Psychiatry Clearance __Cardiac Clearance

__Chest X-ray __Echo/EKG __EGD and pathology

__Lab work (Date: _____) __Medical Clearance

__Colonoscopy (and Pathology, if biopsy was performed)

__Mammogram (and Pathology, if biopsy was performed)

Other: _____

Please send documentation to the address or fax number listed above. If you have any questions regarding specific documentation, please contact this office.

I hereby authorize the release of the above requested medical records to Alabama Bariatrics and Minimally Invasive Surgery, P.C.

Signed: _____

Witness: _____

NON-COVERED SERVICES WAIVER:

I understand that my insurance company may or may not cover services provided to me today. This may include an office visit or a Helicobacter Pylori breath test. I also understand that none of my diagnosis will be changed to satisfy insurance requirements. I understand that I am fully responsible for any charges that my insurance company does not cover for whatever reason. Any charges denied by my insurance company prior to my surgery or procedure will have to be paid in full. If not, then I understand that my surgery or procedure will be postponed until my financial obligations are met.

CONSENT FOR TREATMENT:

This is my authorization and consent for care and treatment by Alabama Bariatrics and Minimally Invasive Surgery, P.C. and its agents. It is understood that while a patient being treated, I will be under the general care of my licensed therapist and I do hereby authorize and consent to all care and treatment administered by Alabama Bariatrics and Minimally Invasive Surgery, P.C. and its authorized representatives and I consent to any further examination, care and treatment which may be deemed advisable and/or appropriate by my physician, licensed therapist, or by authorized representatives of Occupational Therapy of Gadsden, LLC. I acknowledge that no guarantees have been made to rue as to the effect of such examination or treatment on my condition.

PERSONAL VALUABLES:

I acknowledge that Alabama Bariatrics and Minimally Invasive Surgery, P.C. shall not be liable for the loss or damage to any personal property.

PERMISSION FOR DISCLOSURE OF INFORMATION:

This authorizes Alabama Bariatrics and Minimally Invasive Surgery, P.C. and its representatives and employees to release all information, including, but not limited to, copies of medical and other records relative to this treatment, testing and diagnosis to all insurers, third party payors, other health care institutions or entities involved in patient transport or continuing patient care, physicians or agencies performing review functions authorized by contract, law or regulation.

FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned agree(s), whether signing as agent or as patient that in consideration of services to be rendered to patient, the undersigned is obligated to pay for same in accordance with the regular rates and terms; and that should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all reasonable fees, interest and all costs of collection. Returned checks shall incur a $35 fee. Further, the undersigned waives as to its debt all rights of exemption under the constitution and laws of Alabama or any other state as to its personal property. In the event the undersigned and/or patient is entitled to hospital inpatient, outpatient, or Emergency Room benefits of any type, whatsoever, arising out of any insurance or any other party liable to the patient, then the undersigned assigns such benefits to Alabama Bariatrics and Minimally Invasive Surgery, P.C.. The undersigned hereby authorizes and directs that all insurance benefits assigned shall be paid directly to Alabama Bariatrics and Minimally Invasive Surgery, P.C. for the respective services rendered. The undersigned and/or patient agrees and understands that acceptance of insurance coverage is conditional until insurance pays and all charges not paid by insurance are the responsibility of the undersigned and/or patient. The undersigned and/or patient is responsible for the compliance with any pre-certification and/or other requirements of any insurance company or third party payors. The undersigned and/or patient is responsible for any difference not paid by insurance charge structure used by the insurance company or third party payors versus that of the medical provider.

STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER

The undersigned and/or patient certifies that the Information given by him/her in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. The undersigned and/or patient requests that payment of authorized benefits be made to Alabama Bariatrics and Minimally Invasive Surgery, P.C. for any services furnished to him/her. The undersigned and/or patient authorizes any holder of medical or other information about the patient to release to the Health Care Financing Administration, the State of Alabama, their intermediaries, carriers or agents any information needed to determine these benefits or benefits for related services. It is understood that the undersigned and/or patient is responsible to Alabama Bariatrics and Minimally Invasive Surgery, P.C. for any health insurance deductibles and coinsurance.

The undersigned and/or patient certifies that he/she has read the foregoing and agrees and accepts same.

_____ _____ _____

Policyholder Patient/Agent or Representative, Relationship Date

Patient Signature:_____ Date:_____

Print Name:_____

HIPAA Consent for Purpose of Treatment, Payment and Healthcare Operations, Notice of Privacy Policy Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I consent to the use or disclosure of my protected health information by Alabama Bariatrics and Minimally Invasive Surgery, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Alabama Bariatrics and Minimally Invasive Surgery, P.C..

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Alabama Bariatrics and Minimally Invasive Surgery, P.C. This Notice of Privacy Practices also describes my rights and the Alabama Bariatrics and Minimally Invasive Surgery, P.C. duties with respect to my protected health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Alabama Bariatrics and Minimally Invasive Surgery, P.C. is not required to agree to the restrictions that I may request. However, if Alabama Bariatrics and Minimally Invasive Surgery, P.C. agrees to a restriction that I request, the restriction is binding on Alabama Bariatrics and Minimally Invasive Surgery, P.C., William Jay Suggs, M.D., and Andrew Harner, M.D.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to revoke this consent, in writing, at any time, except to the extent that William Jay Suggs, M.D., Andrew Harner, M.D., or Alabama Bariatrics and Minimally Invasive Surgery, P.C. has taken action in reliance on this consent.

Signature of Patient or Personal Representative_____

Name or Patient or Personal Representative_____ Date_____

Relationship to patient_____

ALABAMA BARIATRICS & MINIMALLY INVASIVE SURGERY

W. Jay Suggs, MD FACS FASMBS / Andrew Harner, MD

Decatur – Huntsville

Phone: (256) 274-4523 Fax: (256) 203-8791

Email: office@alabariatrics.com Website: www.alabariatrics.com

Name of PCP: _____

MEDICAL HISTORY: Please answer Yes or No. *In the space beside the disease, note how long you've had it in years.*

	YES	NO		YES	NO
Borderline diabetes (no medications)	☐	☐	Anemia	☐	☐
Diabetes – Insulin	☐	☐	HIV/AIDS	☐	☐
Diabetes – Medications	☐	☐	Anxiety disorder	☐	☐
Sleep Apnea (circle if on CPAP)	☐	☐	Bipolar disorder	☐	☐
Asthma	☐	☐	Depression	☐	☐
COPD	☐	☐	Suicide attempt	☐	☐
Use of home oxygen	☐	☐	Arthritis: Knee pain	☐	☐
Cancer (what type?) _____	☐	☐	Arthritis: Hip pain	☐	☐
Hypertension (high blood pressure)	☐	☐	Lower Back Pain	☐	☐
Heart: History of heart attack	☐	☐	Leg / foot swelling	☐	☐
Heart: History of angina or chest pain	☐	☐	Venous stasis disease: Leg ulcers	☐	☐
Heart: Coronary artery disease	☐	☐	Venous stasis disease: Lymphedema	☐	☐
Heart: Heart failure	☐	☐	Pulmonary embolism (circle IVC Filter if you have one)	☐	☐
Heart: Pacemaker	☐	☐	Blood Clots (DVT)	☐	☐
Stroke or TIA	☐	☐	Stress urinary incontinence	☐	☐
High cholesterol/triglycerides	☐	☐	Kidney disease (circle if on dialysis)	☐	☐
Hyper or **hypo**thyroidism (circle which)	☐	☐	Liver Disease (circle): **NASH Fatty Liver Cirrhosis**	☐	☐
Acid reflux (GERD)	☐	☐	Menstrual history: Post-menopausal	☐	☐
History Stomach Ulcers	☐	☐	Menstrual history: **Infertility** or **PCOS** (circle which)	☐	☐
Gallbladder: gallstones	☐	☐	Last mammogram (year):	☐	☐
Gallbladder: gallbladder attacks	☐	☐	Last Colonoscopy (year):	☐	☐
Other Medical Problems or Hospitalizations (List)			Last EGD (upper endoscopy) (if ever)		

SURGICAL HISTORY:

	Yes	No		Yes	No
Any abdominal surgery?	☐	☐	Colon resection?	☐	☐
Hernia repair (abdominal, groin, etc.)?	☐	☐	Nissen fundoplication/hiatal hernia repair?	☐	☐
Gallbladder removal (cholecystectomy)?	☐	☐	Joint replacement?	☐	☐
Previous Bariatric Surgery?	☐	☐	Open heart surgery?	☐	☐
Hysterectomy?	☐	☐	Others (describe)		

DRUG ALLERGIES: (please do not list seasonal allergies or side-effects such as upset stomach)

SMOKING/vaping HISTORY: Y/N (circle one) **MARITAL STATUS:** **OCCUPATION:**

Packs Per Day:	Years Smoked:	Quit Date:	Vaping: Y/N Quit Date:		

Marijuana HISTORY: Smoke marijuana: Y/N Medical marijuana or cannabis: Y/N Marijuana or cannabis edibles: Y/N

How often:

DRUG/ALCOHOL USE: **HISTORY OF EATING DISORDER? Yes / No**

Servings per week:		History of treatment for alcoholism/drug abuse:	

Name:_____ Date of birth_____

Please Print Clearly

Full Name:_____ DOB:_____ Today's Date:_____

ALABAMA BARIATRICS & MINIMALLY INVASIVE SURGERY

Patient Health Questionnaire/Review of Systems

Please check the box for all symptoms that *currently* apply (not checking indicates you don't have that problem)

√	Constitutional
	Weight Loss
	Weight Gain
	Change in appetite
	Excessive thirst
	Fever
	Fatigue
	Other_____
	I have none of the above symptoms

√	Ear/nose/throat/mouth
	Dizziness/vertigo
	Nose bleed
	Post-nasal drip
	Sinusitis
	Ringing in ears
	Change in voice
	Other_____
	I have none of the above symptoms

√	Cardiovascular
	Palpitations
	Chest pain
	Ankle swelling
	Shortness of breath
	Cold or numb legs or feet
	Leg pain when walking
	Other_____
	I have none of the above symptoms

√	Chest
	Cough
	Blood in sputum
	Bronchitis
	Wheezing
	Difficulty breathing
	Painful breasts
	Lump or mass in breast
	Nipple discharge
	Other_____
	I have none of the above symptoms

√	Gastrointestinal
	Blood in stool
	Abdominal pain or cramping
	Heartburn
	Difficulty swallowing
	Bloating or abdominal swelling
	Diarrhea
	Constipation
	Painful bowel movements
	Nausea
	Vomiting
	Other_____
	I have none of the above symptoms

√	Urinary
	Painful urination
	Difficulty in starting stream
	Urgency or frequency of urination
	Dribbling of urine
	Incontinence
	Other_____
	I have none of the above symptoms

√	Eyes
	Recent vision change
	Wear glasses or contact lenses
	Other_____
	I have none of the above symptoms

√	Skin
	Recent change in moles or other lesions
	Rash
	Ulcers
	Easy bruising or bleeding
	Other_____
	I have none of the above symptoms

√	Neurological
	Numbness in hands or legs
	Fainting
	Forgetfulness
	Slurred or difficult speech
	Other_____
	I have none of the above symptoms

√	Musculoskeletal
	Muscle weakness
	Joint pain
	Muscle pain
	Difficulty walking
	Arm or leg pain
	Other_____
	I have none of the above symptoms

√	Psychological
	Depression
	Anxiety
	Easy crying
	Substance abuse
	Mental illness
	Other_____
	I have none of the above symptoms

Please Complete Both Sides

Full Name:_____ DOB:_____ Today's Date:_____

Family History

Please check if any of the conditions apply to your family and list the family members the conditions apply to

√	Condition	Family Member(s)
	Obesity	
	Bleeding disorder	
	Heart disease	
	Diabetes	
	High blood pressure	
	Stroke	
	Cancer	
	I am adopted and do not know my family history.	

Medications

Please list your current medications including dosage, if you know it. Also include vitamins, herbals, and dietary supplements.

The above is true and correct to the best of my knowledge

Patient Signature **Date**

Office Use Only I have reviewed the patient ROS, PFSH, and med list, making changes above as appropriate

Reviewed by:_____ Date: _____

Updated by: _____ Date: _____

Updated by: _____ Date: _____

Updated by: _____ Date: _____

Updated by: _____ Date: _____

Updated by: _____ Date: _____

Please Complete Both Sides

Alabama Bariatrics GERD Questionnaire

Patient Name: _____ DOB: _____

Date: _____

Please circle "YES" or "NO" to the following questions if these symptoms ***ever*** happen to you.

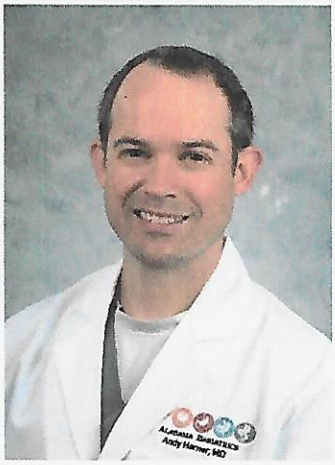
I get a burning feeling in the middle of my chest.	YES	NO
I get pain in the upper part of the middle of my abdomen.	YES	NO
I often have this feeling after a meal or at night.	YES	NO
This burning feeling gets worse when I lie down or bend over.	YES	NO
Over the counter medicines such as acid reducers or antacids help.	YES	NO
I frequently regurgitate (burp up) my food.	YES	NO
I have difficulty or pain with swallowing.	YES	NO
There is a bitter or sour taste in the back of my throat.	YES	NO
I get nauseated.	YES	NO
I have a frequent cough.	YES	NO
I frequently have to clear my throat.	YES	NO
I am often hoarse.	YES	NO
My throat is sore or burns a lot.	YES	NO
I have excess throat mucous or postnasal drip.	YES	NO
I have changed my diet because of heartburn.	YES	NO
I have bloating or gassy feelings.	YES	NO
I have asthma or difficulty breathing.	YES	NO
I have dental erosions or gum disease.	YES	NO
I have anemia.	YES	NO
I have a vitamin B12 deficiency.	YES	NO
I vomit blood.	YES	NO
I have blood in my stool, or it's dark and tarry.	YES	NO

W. JAY SUGGS, MD, FACS, FASMBS

ASSOCIATE PROFESSOR OF SURGERY

&

ANDREW HARNER, MD



ALABAMA BARIATRICS & MINIMALLY INVASIVE SURGERY

Decatur – Huntsville

Main Office: 705 Bank St, Decatur, AL 35601

Phone: (256) 274-4523 Fax: (256) 203-8791

Email: office@alabariatrics.com Website: www.alabariatrics.com

Dear Patient,

I'm so honored that you would entrust Alabama Bariatrics and myself as your bariatric surgeon. EmmaLaura, in office administration and the "Travel patient coordinator;" Cathy, my medical assistant and your "Patient Advocate;" Katie, our nurse practitioner; and multiple on-site and "telehealth" dieticians, are here to help you. They are all eager to answer your medical, insurance, bariatric program, and diet questions. I also encourage your feedback, as well as criticisms, for our program as well as the hospital.

Because of the major time consuming, administrative hours, insurance and paper work that goes into each and every submission, there will be a $125.00 fee due at your pre-op appointment in addition to any out-of-pocket deductibles or percentages required per insurance coverage. There may be additional out of pocket financial obligations on the hospital side that you will be responsible for, including pathology and anesthesia, as per insurance coverage. We highly recommend that you call the hopstial in advance to verify your financial responsibilities and obligations.

Where we operate: Crestwood Medical Center, Huntsville: (256)429-4878 Anesthesia: 1-800-991-0627
Huntsville Hospital, Huntsville: (256)265-1000 Anesthesia: (256)265-1000
Med Surg, Decatur: (256)340-1212

Locations: 705 Bank St., Decatur
333 Whitesport Drive, Suite 205, Huntsville, AL. 35801 (Crestwood campus)

Our hours: Mon-Th 8-5, Fri 8-12

Phone: (256)274-4523

Medical students are also an integral part of the educational aspects of our program, so you'll see them often. In fact, you'll be their best educator!

Please visit us on Facebook (Alabama Bariatrics) and like us! And check out the educational materials and links on our website www.alabariatrics.com. Please help us get the word out about bariatric surgery by clicking on us often, and rating us highly!

Sincerely

W. Jay Suggs, MD FACS FASMBS & Andrew Harner, MD

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Document Charges

This is to inform you that Alabama Bariatrics and Minimally Invasive Surgery, P.C. *may* charge for searching and printing any medical records you may request. We will often print or copy records at the time of your office visit for free. Charges are as follows: $1.00 for the first 25 pages and $.50 for each additional page. This fee is due at the time the records are picked up from our office.

Alabama Bariatrics and Minimally Invasive Surgery, P.C. does charge a fee for filling out FMLA or Disability papers. This fee will be $10 for each packet that has to be filled out. This fee is due prior to the paperwork being filled out.

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HIPAA Notice of Privacy Practices

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

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

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
- **DO NOT use email, Facebook, or other websites and social media for emergency contact.**

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.

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.

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.

- Effective Date of this Notice: January 1, 2016
- Privacy Contact: