105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

PATIENT INFORMATION FORM

Please complete all pages in full. Today's date: ______________

Who referred you to our practice? ____

Child's Information

Child's Legal Name: ______________________________ D.O.B.: ______________

Goes by/Nickname: ______________________________ M / F: ______________

Address: ______________________________________

____

Home phone #: ______________________________

Parent/Guardian Information

Parent/Guardian Name: ______________________________ D.O.B.: ______________

Address: ______________________________ SS#: ______ /_____ / ________

____

Phone Numbers: Home: ______________ Cell: ______________ Work: ______________

Employer: ______________________________ Occupation: ______________

Email: ____

Insurance Company Name: ______________________________ Primary or Secondary

Policy number: ______________________________ Effective Date: ______________

Parent/Guardian Information

Parent/Guardian Name: ______________________________ D.O.B.: ______________

Address: ______________________________ SS#: ______ /_____ / ________

____

Phone Numbers: Home: ______________ Cell: ______________ Work: ______________

Employer: ______________________________ Occupation: ______________

Email: ____

Insurance Company Name: ______________________________ Primary or Secondary

Policy number: ______________________________ Effective Date: ______________

Siblings' Information

Sibling's Name: ______________________________ D.O.B.: ______________

Sibling's Name: ______________________________ D.O.B.: ______________

Sibling's Name: ______________________________ D.O.B.: ______________

Sibling's Name: ______________________________ D.O.B.: ______________

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PATIENT HISTORY FORM

Patient's Name: ______________________________

Birth History

Was this child? Full Term Preterm Adopted
If preterm, how many weeks? __________ If adopted, at what age? __________
Birth Weight: __________ Length: __________
Type of delivery: __________ Obstetrician: __________
Did he/she have any problems in the newborn period? __________

Past Medical History

Please circle any illnesses your child has had and list approximate dates and/or frequency:

Anemia	Heart Murmur	Seizures
Asthma	Pneumonia	Strep throat
Chicken Pox	RSV Bronchiolitis	Urinary infections
Ear infections	Reflux (GERD)	Other: __________

List any surgeries/hospitalizations: __________
List any known allergies: __________
List all medications taken on a regular basis: __________

Family History

Has a family member ever been diagnosed with any of the following?
Please circle and list the relationship. Only include you and the **child's** other parent, siblings, grandparents, aunts, uncles, and cousins.

Anemia	Allergies	Asthma	Bleeding disorder
Cancer	Crohn's disease	Diabetes	Eczema
Emotional problems	Epilepsy	Heart Attack	High blood pressure
High cholesterol	Kidney Disease	Lazy Eye	Psoriasis
Stroke	Thyroid disease	Tuberculosis	Ulcerative Colitis
Unexplained/Sudden Death	Urinary Reflux		

Other __________
If you circled any of the above, please identify the relative: __________
. __________
Is there anything more you would like us to know about your child? __________
. __________
Person completing this form: __________

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CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for **Piedmont Pediatrics** to use and/or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purposes of *treatment, payment, and health care operations.* You may refuse to sign this consent form.

You should read the ***Notice of Privacy Practices*** for **PHI** attached to this form before signing the consent. The terms of the Notice may change from time to time, and you may request a revised copy by asking the **Privacy Office** at **Piedmont Pediatrics**.

You have the right to request that **Piedmont Pediatrics** restrict how **PHI** is used or disclosed to carry out *treatment, payment, or health care operations*. **Piedmont Pediatrics** is not required to agree to requested restrictions; however, if **Piedmont Pediatrics** agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the **Protected Health Information** used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

●You may communicate with the following individual(s) regarding my child's condition or course of treatment: ____.

● You may communicate confidential information to me, including invoices for services, to the following address and/or phone/fax numbers:

____.

_________________________________ ___________________________

Print Name of Individual or Personal Representative Relationship to Patient

_________________________________ ___________________________

Signature of Individual or Personal Representative Date

●As a personal representative, I have the authority to act for the individual because I am the individual's _______________________/Name: ____________________.

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INSURANCE LIABILITY NOTICE

Physician Statement

In many cases, your insurance company will limit payment of a service due to limitations of your policy. If your insurance company does not pay for a service due to policy limitation, you are financially responsible for the payment of that service.

Beneficiary Agreement

I understand that in some cases, certain services will be denied payment from my insurance company due to limitations of my personal policy. In the case that my insurance company denies payment for this service, I understand that I am fully responsible for the payment of this service.

Signed: ____

Date: ____

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Piedmont Pediatrics, LLC Financial Policy

Thank you for choosing Piedmont Pediatrics, LLC as your health care provider for your children. We are committed to providing you and your child/children with the highest caliber of care. As part of your relationship with Piedmont Pediatrics, a clear understanding of our financial policies is important so you will know what actions Piedmont Pediatrics will be undertaking on your behalf as well as what your financial responsibilities are to Piedmont Pediatrics. Your health insurance policy is a contract between you and the insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs.

You are required to:

- Present the proper insurance card for your child/children at the time of service. You must bring a valid insurance card to every visit.
- Present a picture ID (driver's license preferred) for verification of identity; if requested.
- Pay your co-pay at the time of service. As participating providers with your medical insurance plan our office is required to collect your co-payment on the date of service. If you are unable to pay your co-payment at the time of your appointment the office will charge a $10.00 Administrative surcharge for processing your co-payment after your visit.
- Submit payment and assume responsibility for any and all charges your health insurance company does not pay for. This includes your co-pay, co-insurance, policy deductibles, and any and all non-covered services and the outstanding balance after your insurance company has submitted payment to Piedmont Pediatrics, LLC.
- Pay your account balance in full within 30 days of receiving Piedmont Pediatrics statement of outstanding charges. If your payments are not received in a timely manner and your account is not kept current, your account will be sent to Piedmont Pediatrics Third Party collection agency. Please note you will be responsible for all collection fees. Provided below is a more detailed description of your financial responsibilities.
- You are responsible for knowing the benefits and provisions of your particular insurance plan. If you have any questions regarding your benefits, please contact your carrier prior to your visit in the office.

Fees and Insurance Coverage

We request that you be able to provide valid insurance coverage at every office visit. If we are unable to verify active coverage, any and all fees for your services will be due on the date of service. Insurance claims are filed as a courtesy with the participating plans when there is a valid insurance card provided. You must report any insurance changes to the office as soon as possible.
Any information that is inaccurate or received after the date of service may not be billable to the insurance carrier (in some cases) and may become the responsibility of the account guarantor.

When adding a newborn to your insurance plan, please check with your Human Resources department about requirements of your particular plan. Most plans require that newborns be added to the policy within 30 days of birth.

Many insurance policies require prior authorization for tests, including lab and radiology, procedures, specialists' referral visits or hospital admissions. While we try to assist our families with these guidelines, it is

the responsibility of the policy holder to know and understand these requirements in order to avoid any costly penalties and denials by your insurance company.

Responsibility for Payment

Even though you have health insurance, you as the guarantor are responsible for payment of all services provided by Piedmont Pediatrics. Piedmont Pediatrics will bill your insurance company for all services rendered, with the information you have provided us. If your insurance information has changed, please notify us immediately so we may bill the correct insurance carrier.

Co-Payment

Your health insurance policy may state that you must pay a co-payment for all physician visits. This payment is due the day the services are rendered to your child/children. If, for an unforeseeable reason, you do not have the co-payment amount with you at the time of service, please be aware that Piedmont Pediatrics will be charging you an administrative surcharge of $10.00 for processing your co-payment after your visit. Piedmont Pediatrics has a contractual agreement with the health insurance carriers to collect all co-pays on the date the services are rendered. Piedmont Pediatrics accepts cash, personal check, Visa, MasterCard and American Express.

Divorced Parents

Piedmont Pediatrics will not get involved in custodial, separation or financial disputes involving or relating to divorced parents for a minor child(ren) to whom we provide services. The parent who signs the financial policy and registration form of the minor child(ren) will be the responsible party for payments of services rendered. Please note that the court Divorce Decree is an agreement between the two divorcing parties and not between Piedmont Pediatrics and the parents.

Medical Records

Requests for medical records require a signed Medical Release Form stating the authorization of release from Piedmont Pediatrics to either the parent or current physician's office. After one (1) copy of medical records, there will be a charge in accordance with the guidelines set forth by the State of Georgia for copying medical records. All medical records will be subject to a processing fee and will only be released after the fee is collected. Please be advised that we are unable to fax medical records.

If you are transferring from another pediatrician, we request that you have those medical records transferred to our office before services are rendered here.

Annual Administrative Fee

Piedmont Pediatrics charges an Annual Administrative Fee of $10.00 per child/$30.00 per family maximum for forms you may require throughout the year including camp, school forms, immunization records, hearing and vision records, etc. This fee must be paid prior to pick up of forms/records.

Please keep in mind that due to the large volume of forms we complete daily that we have a 5-7 business day turn around time. We provide our parents with a copy of the super bill at the time of service, additional billing copies required for tax purposes will be subject to a charge.

Remaining Balance After Your Insurance Company has paid

Piedmont Pediatrics will submit a claim to your primary health insurance company for services provided. Piedmont Pediatrics does not submit claims to any secondary health insurance companies. You will be responsible for submitting claims to that carrier. Once your insurance company has processed your claim, Piedmont Pediatrics will post any payment it receives to your account. If there is a remaining balance, the balance will now be your responsibility. This balance may include your deductible, co-insurance and any and all non-covered charges. As stated before, we request that you pay your balance in full within 30 days of

receiving your statement. We encourage our patients to enroll in our Autopay program for a more convenient and efficient way to pay your remaining balance.

Missed Appointment/ No Show Visits

Missed appointments and late cancellations/rescheduling represent a cost to us, to you and other patients who could have been seen in the time set aside for you. **We require at least a 24-hour notice** for any cancellations or rescheduling of a previously scheduled appointment. Failure to cancel or reschedule your appointment 24 hours in advance will result in a $35.00 administrative fee per appointment. These fees are not covered by your insurance company and are the sole responsibility of the guarantor on the account.

Dismissal

If you are dismissed from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You will have to place your child in the care of another physician. We will refer you to someone if you need.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Noncompliance, which means you won't follow physician instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical records to your new doctor after you let us know who it is and a release form is signed.

Returned Checks

Piedmont Pediatrics charges a service charge of $30.00 for all returned checks.

Saturday Office Hours

Piedmont Pediatrics charges an additional fee for Saturday services. We operate on Saturdays for sick children only. This fee may or may not be covered by your insurance carrier.

Splitting Vaccines/Shot Only Clinics

If you are a parent that has elected to 'split up' vaccines or vary the vaccination schedule, you will be required at each visit to pay any co-payment according to your plan benefits. Please verify with your insurance company the impact these particular situations/visits may have on your benefits.

Walk in Fee

Piedmont Pediatrics reserves the right to charge a walk-in fee of $25.OO. This fee is charged to discourage walk-in visits that disrupt the schedule. This may be charged at the discretion of the physician for patients that disrupt the schedule or repeated walk-in patients.

I have read the above financial policy for Piedmont Pediatrics, LLC and I agree to the terms listed above.

Print Name: ______________________________

Signature: ______________________________ Date: __________________

Piedmont Pediatrics AutoPay Policy

We are committed to providing you with exceptional care, as well as making our billing processes as simple and efficient as possible. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, effective October 1st, 2019, Piedmont Pediatrics will offer an AutoPay option for all patients to keep an active credit card on file with us. Similar to hotel payment models, you are asked to swipe a credit card number at the time you check in and the information will be held securely until your insurance provider has paid their portion for the services rendered and notified us of the amount your policy determines falls to patient responsibility.

The Process

Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.

- When we receive the EOB, we will enter all pertinent payment information into our system. You will then receive an email notifying you of your patient responsibility portion. Your credit card will be charged, typically 5 business after you receive the email. After your card is charged, you will receive a second email containing a copy of the receipt.

Your card on file will only be charged for the following:

- Visit payments not collected from you at the beginning of your visit such as copayments, co-insurance, and deductibles.
- Any non-covered services and/or denial of coverage by your insurance company.
- No show or late cancellation charges.
- Self-Pay payments.
- Outstanding balances.

If the credit card we have on file for you changes, please notify our billing team **IMMEDIATELY**. You are welcome to leave an **HSA (Health Savings Account)** or **Flex Plan** Card on File. You may also pay for your visits with cash or a personal check at the time services are rendered. You may revoke your authorization to keep your credit card on file by submitting a 15-day notification in writing.

In the future, should you decline to participate in the Autopay option, a billing fee of **$5.00** will be added to your account for any balances we must attempt to collect through mailing a traditional monthly statement.

If there is a problem with your bill/claim and it is brought to our attention after your card payment processes, we will investigate it and if we owe you any money, we will refund it to the same card within 5 business days of resolution of the issue.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. You will be given time to contact our office and speak with one of our billing experts to discuss your charges before we process your credit card on file.

AutoPay Agreement

Piedmont Pediatrics recommends keeping your credit card, debit card, or HSA/FSA card on file as a convenient method of payment for the portion of our services that your insurance doesn't cover, but for which you are responsible according to your contract with your insurance carrier.
Your credit card information will be kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and only after the insurance portion of the claim has been paid and posted to the account by said insurance.

To ensure that your credit card information is kept safe, Piedmont Pediatrics uses **Complete Merchant Solutions (CMS)** to store your encrypted credit card information.

Patient Full Name: ____
(Please Print) *(Date of Birth)*

Patient Full Name: ____
(Please Print) *(Date of Birth)*

Patient Full Name: ____
(Please Print) *(Date of Birth)*

□ ***Visa*** □ ***AMEX*** □ ***Master Card*** □ ***Discover*** □ ***HSA/Flex Spending Card***

Last 4-digits of Card number*:*

Expiration Date:

Name of Card Holder:

Email Address

(Autopay notifications and receipt confirmations are sent via email)

Signature of Cardholder: ________________________ **Date:** ________________

I (We), the undersigned, authorize and request **Complete Merchant Solutions (CMS)** to securely store my credit card information.

I (We), the undersigned, understand that **Piedmont Pediatrics, LLC** will only charge my credit card should I have an outstanding balance or any leftover balance from a processed claim. This agreement will remain in effect until the expiration of my credit card account.

I (We), the undersigned, understand that I may revoke this form at any time by submitting a 30-day notification in writing.

Signature of Parent/Guardian: ____________________ **Date:** __________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

1. ABOUT THIS NOTICE

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and our Business Associates' subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

"Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

2. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health

care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Under the law, we <u>must</u> disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Uses and Disclosures of Protected Health Information that Require Your Prior Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Your prior written authorization is required for:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes
- Disclosures of PHI that constitute a "sale" of protected health information

We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

4. YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply). Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications. You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We will also make available copies of our new notice if you wish to obtain one.

We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment.

5. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Practice Manager/Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our Practice Manager/Privacy Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form.

Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Name:___________________________Signature:________________________Date:________