ADVANCED MEDICAL CARE CENTER, LLC
INSURANCE INFORMATION FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability.

Patient Information:

Last Name	First Name	Middle Initial
Street Address	City/State/Zip Code	Social Security #
Phone Number/Other	Date of Birth	Male or Female
Cell Phone	Email	Marital Status S / M / D / W
Emergency Contact Name/Phone #	Pharmacy Name & Phone #	

Employer Information:

Name	Work Number	Occupation
Address	City/State/Zip Code	

Insurance Information:

Name of First Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	
Name of Secondary Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security	Address	Zip Code
Home Number	Employer's Name	Work Number

I understand that if this or any other visit precedes the effective date of my insurance, or is not covered by my insurance, I will be held responsible for all fees incurred as a result of this and any subsequent visits. I hereby authorize payment directly to my medical provider with Advanced Care Medical Group, INC for any medical benefits payable to me under the conditions of my policy for services rendered at Advanced Medical Care Center, LLC. I hereby give consent to release to authorized persons financial and medical information concerning care, treatments and charges as may be required to complete all claims for benefits.

Signature of Patient or Authorized Representative:	**Date:**

Advanced Medical Care Center, LLC

Health History Form

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Pharmacy Name and Phone Number: _____

Reason for Today's Visit: _____ Effective Side (if applicable) _____

Associated Signs & Symptoms: _____

Duration of the Problem: _____

List any allergies to Medications, Latex and/or Foods, Include Reaction to Each:

□ No Known Allergies

_____

Review of Systems: Please Circle Any **Current** symptoms below:

General Symptoms:
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out.

Eyes:
Vision, loss, eye pain, blurred vision

Ears/Nose/Mouth & Throat:
Sore throat, runny nose, hearing loss, problems with mouth, voice changes.

Breasts:
Lumps, skin changes, nipple discharge

Lungs & Heart:
Chest pain/pressure, irregular heartbeat, cough, wheezing, breathing problems

Skin:
Rashes, changes moles, changes in hair/skin/nails

Men Only:
Difficulty starting or weak stream, difficulty getting/maintaining an erection, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps/swelling, possible sexually transmitted infections.

Neurological:
Unusual or new headaches, weakness or numbness, falling

Abdomen:
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

Sleep:
Difficulty falling asleep, frequent awakening.

Musculoskeletal:
Joint/muscle pain, muscle weakness

Mood:
Worry too much, felt down and depressed in the last two Weeks, loss of desire to do things you used to enjoy, thoughts of self-harm or suicide.

Other:
List any symptoms not mentioned
_____
_____
_____

Women Only:
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine.

Menstrual Cycle Questions:
Still having cycle? □No □Yes
□Regular □Irregular
Date of Last Period: _____
Birth Control Type: _____
Hysterectomy: □No □Yes
If yes, what age? _____
Due to what? _____
Number of Pregnancies:
Vaginal Deliveries _____
C-Section Deliveries _____
Other _____
Diabetes in pregnancy? □No □Yes
Have you ever had an abnormal pap or colposcopy? □No □Yes

Past Medical History: Have you **ever** been treated for any of the following medical conditions?

□ No Known Medical Problems

□ Seasonal Allergies	□ Gastric Reflux	□ Liver Disease
□ Anxiety	□ Heart Disease	□ Dizziness/Vertigo
□ Asthma/COPD	□ High Cholesterol	□ Migraines
□ Atrial Fibrillation	□ Hypertension	□Other Conditions not listed:
□ Depression	□ Thyroid Disorder	_____
□ Diabetes	□ TIA/Stroke	_____
□ Cancer (Type)_____	□ Kidney Disease	_____
□ Arthritis	□ Back/Joint Pain	

List Previous Hospitalization/Surgeries/Serious Illness and Date of Event: □ None

_____

_____

_____

List All Medications: (Include dose, frequency and over the counter medications/supplements):
□ None

_____

_____

_____

_____

_____

Refill Needed on Any Medications? □ No □ Yes, _____

Family History: Include history of diabetes, heart disease, hypertension, colon/breast/ovarian cancer, other cancers, autoimmune disease, depression, and osteoporosis.

Relative:	Health History	Alive/Deceased
Mother:		
Father:		
Sister/Brother:		
Children:		

Social History:

Marital Status: □Single □Married □Partner □Widowed □Separated

Children: □No □Yes Ages:_____

Alcohol Use: □No □Yes Number of Drinks/Frequency:_____

Tobacco Use: □Never □Currently Smoke: __pack(s) per day for___years
□Previously Smoked: pack(s) per day for___years, Quit ___
□Chewing Tobacco for _____years, Quit_____

Caffeine Use: □None □1-3 servings/day □4-6/day □ >6/day □Type:_____

Drug Use: □None □Marijuana □Cocaine □Heroin □Other:_____

Exercise: □None □Days per Week ____ Type of Exercise:_____

Trouble Sleeping: □No □Yes Occupation:_____

Preventative Screening:

Do you wear seatbelts/helmets?
□ No □Yes □Sometimes

Do you wear sunscreen?
□ No □Yes □Sometimes

Do you have an eye exam at least every two years?
□ No □Yes

Do you have a dental exam at least yearly?
□ No □Yes

When was your last: (year)
Colonoscopy_____
Lipid Panel_____
Fasting Glucose:_____HgbA1c_____

When was your last immunizations for (year):
Tdap (Tetanus,Diphtheria,Pertussis):_____
Influenza (Flu):_____
Pneumovax (Pneumonia):_____
Prevnar (Pneumonia):_____
Gardasil (HPV):_____

Women:
Date of Last:Pap Test:_____
Mammogram:_____YR _____Location
Chlamydia Screening:_____
Bone Density:_____
Any history of abnormal findings with tests in past?
□ No □Yes, _____

Men:
Date of Last PSA Screening_____
Date of Last Prostate Exam_____

Do you have an Advanced Directive? □ No □Yes
If yes, please provide the office with a copy for your records.
If no, would you like an information packet concerning Advanced Directive? □ No □Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

I hereby give consent for medical treatment to the care providers with Advanced Care Medical Group, Inc. to care for myself, or I am authorized by the patient as his/her general agent to give consent for such treatment.

_____ _____ _____
Signature of Patient/Guardian Print Name and Relationship if Representative Date

ADVANCED MEDICAL CARE CENTER, LLC
FINANCIAL AND BILLING POLICIES

Thank you for choosing Advanced Medical Care Center, LLC for your health care needs. For your convenience, our medical group, Advanced Care Medical Group INC participates with a variety of insurance plans and will directly bill your insurance under these plans.

It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. It is the patient's responsibility to know your insurance coverage. Your insurance company will only pay for services that are covered under your insurance policy, with no exceptions. If you have any questions, call your health plan's member services department. Their number should be listed in your benefit plan booklet or on your ID card.

Inform us of Changes:
If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and make you personally responsible for the cost of the entire visit.

Bring your Health Insurance Information and Photo ID:
Bring your photo ID and all insurance cards on the day of your visit. If you do not have your insurance information available at the time of service, the full office visit fee will be due at the time of service. NO EXCEPTIONS. We will later file that date of series for you and upon receipt of an insurance payment we will refund any overpayment due to you. **We are not contracted with straight Medi-Cal, or any Medi-Cal managed care plan**, and therefore do not accept, nor bill, any service to Medi-Cal or Medi-Cal managed plans under any circumstances.

I understand that Advanced Medical Care Center, LLC and Advanced Care Medical Group, INC does not bill for the services of pathology, laboratory and/or imaging services, and that I will receive a separate bill for these services. I authorize the release of pertinent medical information to my insurance company to obtain authorization for the necessary procedures or to facilitate payment of a claim.

Co-payments, Deductibles and Coinsurance:
Co-payments are due at the time of your office visit. Under the terms of our contract with the various insurance plans, we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, debit, VISA, MasterCard and Discover.

Deposits:
For certain procedures not covered by insurance, you may be required to pay a deposit or pay for the service in full, prior to treatment.

Patient Responsibility Balances:
All patient responsible balances must be paid in full upon receipt of your statement. You should have already received an explanation of benefits from your insurance carrier. By this time, at least 30 days has passed since your visit and payment of balance is your responsibility.

Who can Discuss a Bill?
Confidentiality is important. Our Medical Billing Specialist may only speak with the patient, or the person designated in writing by the patient to receive the bill(s), on behalf of the patient. Thank you for understanding our billing policies. All billing inquiries are handled by our biller. If you should have any questions regarding your bill or the status of your account, please contact our biller at **559-636-1586.**

I have read, understand, and agree to the above billing policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibilities.

I authorize my insurance benefits be paid directly to medical provider with Advanced Care Medical Group, INC and authorize the release of pertinent medical information to my insurance company when requested or when needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform Advanced Medical Care Center, LLC of any changes regarding my personal billing information or my insurance billing information.

Advanced Care Medical Group, INC reserves the right to bring action for the entire balance owed on my account, if default in payments is made.

_____	_____	_____
Patient Signature/Responsible Party	**Name Printed**	**Date**

AMCC Representative Witness:_____ Date_____

Jennifer Carey, HIPAA Privacy and Security Officer
Advanced Medical Care Center, LLC
3130 W. Caldwell Ave.
Visalia, CA. 93277
559-635-7800 Fax 559-635-7805

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Advanced Medical Care Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Advanced Medical Care Center has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Advanced Medical Care Center will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Advanced Medical Care Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Advanced Medical Care Center has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Advanced Medical Care Center.

FORM Us

ADVANCED MEDICAL CARE CENTER, LLC

Acknowledgement of Receipt of Patient Health Care Rights & Responsibilities, Advance Directive Policy, Ownership Disclosure and Consent for Treatment

I acknowledge that I have received a copy of Advanced Medical Care Center's:

1. **Patient Health Care Rights & Responsibilities**,

2. **Advance Directive Policy and Procedure**,
   An "Advance Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. If you have an Advance Directive please notify AMCC and provide a copy to be kept in your medical record.

   It is the policy of Advanced Medical Care Center, for all patients, regardless of the content of Advance Directive, that if an adverse event occurs during treatment at AMCC, the personnel will initiate resuscitative or other stabilizing measure and transfer to an acute care hospital for further evaluation, Cal. Probate Code 4735-4736. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with the patient's wishes, advance directive, or health power of attorney.

   If you would like a copy of the official State Advance Directive forms, visit http://www.calhospital.org/sites/main/files/file-attachments/forms3.pdf , or speak to your provider today for further information and receive an information packet.

3. **Ownership of Advanced Care Medical Group, Inc and Advanced Medical Care Center, LLC**
   As a patient, you have the right to be informed of all Providers that have ownership in this facility. If you receive a referral from this office, you have the right to obtain referral services from Providers other than the Providers listed below as owners. Upon the time of referral, a list of providers who furnish the same services in your area will be provided.

Advanced Care Medical Group Owners	**Advanced Medical Care Group Owners**
William C. Holvik, MD NPI 1346225364	Shawn F. Cardoza, FNP NPI 1104937002
Shawn F. Cardoza, FNP NPI 1104937002	Paul R. Mayo, DPM NPI 1396002887

4. **Consent to Medical Treatment**
   I consent to the evaluation and treatment by an Advanced Care Medical Group, INC Provider. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may provide health benefits, but they may also involve significant risks. I acknowledge that no guarantees have been made to me regarding the results of the evaluation and treatment. I acknowledge that I have the right to actively participate in decisions regarding my care, including the right to provide informed consent or to refuse any proposed treatment, directed by my provider.

I certify that I have read the foregoing and that I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign and accept the terms on his/her behalf.

Patient Signature:_____**Patient Name:**_____**Date:**_____

If signed by the patient's personal representative:

Representative Sign: _____**Relationship to Patient:**_____**Date**:_____

AMCC Office Staff Signature: _____ **Date:** _____

Advanced Medical Care Center, LLC

PATIENTS RIGHTS

1. The patient has the right to be treated with respectful, considerate, and dignity at all times.

2. The patient has the right to exercise these rights without regard to sex, cultural, economic, educational, or religious background.

3. The patient has the right to informational and personal privacy. All discussions and consultations involving patient's care will be done in a sensitive manner and only with those directly involved in delivery of care. Those not directly involved in the patient's care must have permission to be present. The patient has the right to disclosure of records to be treated confidentially, except when required by law. All medical disclosures of the patient's personal health information are in compliance with federal HIPAA regulations.

4. The patient has the right to personal privacy and care in a safe setting, free from all forms of abuse and harassment.

5. The patient has the right to knowledge of the name of the medical provider who is primarily responsible for coordinating his/her care and the name of any other staff who will see them.

6. The patient has the right to be informed from their medical provider about their current diagnosis, treatment, and prognosis in language the patient can understand. When the patient is unable to comprehend, the information will be made available to an appropriate individual on the patient's behalf.

7. The patient has the right to receive from their medical provider adequate information to give informed consent regarding their procedure or treatment. The aforementioned information will not necessarily be limited to the specific procedure, significant risks, and possible outcomes. The patient has the right to know who will be performing the procedure. The patient has the right to know and understand what to expect related to their care and treatment.

8. The patient has the right to be actively involved in decisions regarding their medical care. This includes the patient's right to deny treatment as allowed by the law. The patient has the right to be informed of the medical risks involved in denying treatment. The patient has the right to change their primary physician.

9. The patient has the right to adequate follow through on care. The patient will be informed by the healthcare professionals of their responsibilities following discharge.

10. The patient has the right to be advised and right to decline experimental procedures of treatment.

11. The patient has the right to request an itemized explanation of their total bill after services are rendered. The patient has the right to information regarding fees for service, payment policies and obligations.

12. The patient has the right to request and inspect their personal health information. The patient has the right to request amendment to their health information if it is incorrect or incomplete. Please submit request in writing.

13. The patient has the right to express their concerns and receive a response in a timely manner. **To file a complaint at Advanced Medical Care Center, LLC please contact the Administrator at 559-635-7800.** The complaint can also be filed with the California Department of Public Health, 4540 California Avenue Suite 200, Bakersfield, CA 93309, 1-661-336-0543.

14. Medicare patients should visit http://www.cms.hhs.gov/center/ombudsman.asp to understand your rights and protections.

PATIENT RESPONSIBILITIES

1. The patient has the responsibility to provide to the best of their knowledge all relevant information regarding their health. They have the responsibility of reporting any unexpected changes in their health.

2. The patient has the responsibility of following treatment(s) plan as requested by the provider or other acting healthcare professional. The patient must be compliant and involved in their care. Ask questions if you do not understand.

3. The patient has the responsibility of fulfilling any financial obligations resulting from services rendered.

4. The patient has a responsibility of following patient conduct set forth by Advanced Medical Care Center. The patient is responsible for being considerate of the rights of other patients and office personnel. A patient may be refused services for being under the influence of drugs and alcohol, belligerence/threatening/harassing to others, no payment for services, patient refusal to sign for treatment and/or payment, and/or ongoing and repeated noncompliance.

Note this is a NPP that reflects Omnibus changes as of March 2013

ADVANCED MEDICAL CARE CENTER, LLC

NOTICE OF PRIVACY PRACTICES

Effective Date: October 1, 2015

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.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:

Privacy Officer: Jennifer Carey
Phone Number: 559-635-7800

Section A: Who Will Follow This Notice?

This Notice describes Advanced Medical Care Center's (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

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

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you about raising money for the Provider. We

only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'Opt-out' of these communications.

- **Authorizations Required**
  We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

- **Psychotherapy Notes**
  Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **Provider Directory.** We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **E-mail Use.**
  E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

  You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

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

    - a brief description of the breach, including the date of the breach and the date of its discovery, if known;
    - a description of the type of Unsecured Protected Health Information involved in the breach;
    - steps you should take to protect yourself from potential harm resulting from the breach;
    - a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;

- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

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

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website.

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services;
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

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

provided to you.

Section I: Organized Healthcare Arrangement

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules.

Original Effective Date: April 14, 2003.

References

- Stericycle Online Pivacy Risk Assessment
- PRA Line Items C.2, C.3, C.4, C.5, D.3, D.4
- §164.520(c)(2)