Advance Medical Home Physicians

PATIENT REGISTRATION

_____ _____ _____/_____/_____ _____/_____/_____ ____

Title **Last** **First** **M.I.** **SSN** **D.O.B.** **Sex**

_____ _____ _____

Street Address **City** **Zip**

_____ _____ _____

☐ (check if same)**Billing Address** **City** **Zip**

_____

Email: **Phone** **Phone Type** (cell?) **Phone** **Phone Type** (home?)

Communication Preference (check all that are permitted):

☐ Call Cell ☐Call Home ☐Leave Voicemail ☐ Send Email ☐ Send Text ☐ *No Texts* ☐ Mail

Race: ☐ American Indian/Alaska Native ☐Asian ☐Black/African American☐Native Hawaiian or Pacific Islander ☐White ☐Other___

Ethnicity: ☐Hispanic or Latino☐Not Hispanic or Latino **Language Preference**: _____

Employment Status: ☐Employed☐Not Employed☐ Retired **Marital Status** _____

INSURANCE:

☐**Primary:** _____ Member ID: _____ Phone: _____

☐**Secondary**: _____ Member ID: _____ Phone: _____

☐Injury Claim#_____ Adjuster's Name: _____ Phone: _____

☐Injury Relate Condition:_____

Responsible Party (if other than self):

Name: _____ Phone: _____Relationship:_____

Address: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____Relationship:_____

Address: _____

Pharmacy Name: _____ **Pharmacy Phone**: _____

Assignment of Benefits/Acknowledgement of HIPAA Privacy Practices

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Advance Medical Home Physicians for medical or surgical services or items rendered to me or my dependent by Advance Medical Home Physicians. Should my insurance carrier deny Advance Medical Home Physicians payment, I understand that I am financially responsible for the charges. I authorize Advance Medical Home Physicians to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information. I acknowledge that I have been given a Notice of Privacy Practices.

_____

Signature **Date**

PATIENT'S PAST MEDICAL HISTORY

(List condition start date and treating physician)

- ☐ Alcoholism _____
- ☐ Allergy to eggs_____
- ☐ Allergic Rhinitis_____
- ☐ Allergy to milk products _____
- ☐ Allergy to peanuts _____
- ☐ Allergy to seafood _____
- ☐ Anemia _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial fibrillation _____
- ☐ Benign essential hypertension_____
- ☐ Cervicalgia _____
- ☐ Chest pain _____
- ☐ Chronic pain syndrome_____
- ☐ Circulatory system disorder_____
- ☐ Congestive heart failure _____
- ☐ Depression_____
- ☐ Diabetes _____
- ☐ Diabetes mellitus without mention of complication, type ii or unspecified type, uncontrolled_____
- ☐ Emphysema _____
- ☐ Generalized anxiety disorder_____
- ☐ Gout _____
- ☐ Headache_____
- ☐ Hearing loss _____
- ☐ Heart attack_____
- ☐Heartburn _____
- ☐ Herniated Disc_____
- ☐ High blood pressure [hypertension] _____
- ☐ High cholesterol_____
- ☐ High lipids _____
- ☐ Hypogonadism_____
- ☐ Hypothyroid_____
- ☐ Insomnia_____
- ☐ Iron deficiency anemia secondary to inadequate dietary iron intake_____
- ☐ Irritable bowel syndrome _____
- ☐ Kidney failure _____
- ☐ Lumbago_____
- ☐ Lumbosacral spondylosis w/o myelopathy_____
- ☐ Measles_____
- ☐ Migraine _____
- ☐ Mitral valve disorder _____
- ☐ Mixed hyperlipidemia _____
- ☐ Morbid obesity_____
- ☐ Myalgia and myositis_____ unspecified
- ☐ Osteoporosis _____
- ☐ Osteoarthrosis localized primary involving lower leg _____
- ☐ Pain in joint involving shoulder region _____
- ☐ Pain in limb_____
- ☐ Pressure ulcer, buttock
- ☐ Pressure ulcer, lower_____ back
- ☐ Pressure ulcer _____
- ☐ Pressure ulcer, stage i _____
- ☐ Pressure ulcer, stage ii_____
- ☐ Pressure ulcer, stage iii _____
- ☐ Pressure ulcer, heel, stage iv _____
- ☐ Pressure ulcer, unspecified stage_____
- ☐ Pressure ulcer, unstageable _____
- ☐ Pressure ulcer, upper back _____
- ☐ Psoriasis_____
- ☐ Rosacea _____
- ☐ Scabies_____
- ☐ Sinusitis_____
- ☐ Smoking_____
- ☐ Sciatica_____
- ☐ Skin disorder_____
- ☐ Stroke_____
- ☐ Ulcer of other part of foot_____
- ☐ Ulcer of heel and midfoot_____
- ☐ Unspecified ulcer of lower limb_____
- ☐ Urticarial_____
- ☐ Varicella_____
- ☐ Visual impairment_____
- ☐ Venous (peripheral) insufficiency unspecified_____
- ☐ Vitiligo _____
- ☐ Warts_____
- ☐ _____

Patient Signature: _____ ***DATE:*** _____

FAMILY HISTORY

(List relationship, age, condition start age)

- ☐ Alcoholism _____
- ☐ Allergy to eggs_____
- ☐ Allergic Rhinitis_____
- ☐ Allergy to milk products _____
- ☐ Allergy to peanuts _____
- ☐ Allergy to seafood _____
- ☐ Anemia _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial fibrillation _____
- ☐ Benign essential hypertension_____
- ☐ Cervicalgia _____
- ☐ Chest pain _____
- ☐ Chronic pain syndrome_____
- ☐ Circulatory system disorder_____
- ☐ Congestive heart failure _____
- ☐ Depression_____
- ☐ Diabetes _____
- ☐ Diabetes mellitus without mention of complication, type ii or unspecified type, uncontrolled_____
- ☐ Emphysema _____
- ☐ Generalized anxiety disorder_____
- ☐ Gout _____
- ☐ Headache_____
- ☐ Hearing loss _____
- ☐ Heart attack_____
- ☐Heartburn _____
- ☐ Herniated Disc_____
- ☐ High blood pressure [hypertension] _____
- ☐ High cholesterol_____
- ☐ High lipids _____
- ☐ Hypogonadism_____
- ☐ Hypothyroid_____
- ☐ Insomnia_____
- ☐ Iron deficiency anemia secondary to inadequate dietary iron intake_____
- ☐ Irritable bowel syndrome _____
- ☐ Kidney failure _____
- ☐ Lumbago_____
- ☐ Lumbosacral spondylosis without myelopathy _____
- ☐ Measles_____
- ☐ Migraine _____
- ☐ Mitral valve disorder _____
- ☐ Mixed hyperlipidemia _____
- ☐ Morbid obesity_____
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- ☐ Pain in limb_____
- ☐ Pressure ulcer, buttock
- ☐ Pressure ulcer, lower_____
- ☐ Pressure ulcer back _____
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- ☐ Pressure ulcer, unspecified stage_____
- ☐ Pressure ulcer, unstageable _____
- ☐ Pressure ulcer, upper back _____
- ☐ Psoriasis_____
- ☐ Rosacea _____
- ☐ Scabies_____
- ☐ Sinusitis_____
- ☐ Smoking_____
- ☐ Sciatica_____
- ☐ Skin disorder_____
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- ☐ Ulcer of heel and midfoot_____
- ☐ Unspecified ulcer of lower limb_____
- ☐ Urticarial_____
- ☐ Varicella_____
- ☐ Visual impairment_____
- ☐ Venous (peripheral) insufficiency unspecified_____
- ☐ Vitiligo _____
- ☐ Warts_____
- ☐ _____

Patient Signature: _____ ***DATE:*** _____

SOCIAL HISTORY

Cigarette Smoker?

☐Never smoker ☐Current every day smoker ☐Current some day smoker ☐Former smoker
☐Smoker, current status unknown ☐Heavy tobacco smoker ☐Light tobacco smoker

Do you drink Alcohol?

☐No ☐Yes: ☐Beer ☐Liquor ☐Wine _____
☐Socially ☐minimally ☐infrequently # of drinks per day/week/month

Drug Use? ☐No ☐Yes: _____

Sexually Active? ☐No ☐Yes:

==========

IMMUNIZATION

Are your immunization records up to date? ☐Yes ☐No

Date of last immunization:_____ Administering Physician :_____

Date of last immunization:_____ Administering Physician :_____

Date of last immunization:_____ Administering Physician :_____

Date of last immunization:_____ Administering Physician :_____

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WAIVER OF SERVICES

I am acknowledging that I have been recommended to undergo preventative health care screening, and other tests by my physician. My signature below acknowledges that these tests were explained to me, offered to me, and recommended to me. I am checking off the boxes for the service **I DO NOT WANT** performed.

I do not want the following tests performed:

MALE: ☐Colon Cancer Screening ☐Prostate Cancer Screening ☐Pneumonia Vaccine
☐Influenza Vaccine ☐Cholesterol Check

FEMALE: ☐Colon Cancer Screening ☐Breast Cancer Screening(mammogram) ☐Pneumonia Vaccine
☐Cervical Cancer Screening(pap smear) ☐Influenza Vaccine ☐Cholesterol Check

Patient Signature: _____***DATE:***_____

PAST SURGICAL HISTORY

Date Doctor & Hospital

☐Adenoidectomy_____
☐Appendectomy_____
☐Carpal tunnel_____
☐Cholecystectomy _____
☐Ear tubes _____
☐Hernia repair _____
☐Hysterectomy _____
☐Tonsillectomy_____
☐Burr hole craniotomy_____
☐ VP shunt placement_____
☐ Other_____
☐ Retinal laser surgery left eye_____
☐ Lasik eye surgery both eyes
☐ Cataract extraction left right _____
☐ LT HRT CATH coronary artery balloon angioplasty
☐ LT HRT CATH with angioplasty and stent placement
☐ CABG (coronary artery bypass graft--open heart surgery) _____
☐ Valve replacement surgery (open heart surgery)_____
☐ Endoscopic heart valve replacement surgery
☐ AV fistula (native artery to native vein_____
☐ AV fistula graft (a PTFE white tube connects the artery to vein)
☐ Carotid endarterectomy (removal of plaque out of carotid artery)
☐ Pacemaker _____
☐ Defibrillator_____
☐ Thyroid nodule biopsy (fine needle biopsy)
☐ Thyroidectomy partial_____
☐ Thyroidectomy complete_____
☐ Insulin pump placement _____
☐ Endotracheal, Intubation_____
☐ Tracheostomy creation_____
☐ Current trach is in place_____
☐ Bronchoscopy_____
☐ Thoracosopy-- VAT video assisted thoracoscopy_____
☐ Thoracoscopy __ VAT with manual brillo roughing of lining_____
☐ Pleurodesis_____
☐ VAT and lung resection (for cancer)_____
☐ VAT with pneumonectomy (lung removal) partial
☐ Gastric Bypass _____
☐ Gastric Sleeve Lap Sleeve_____
☐ Gastric band placement . Lap band _____
☐ Laparoscopic. adrenalectomy (adrenal gland removal) _____
☐ Appendectomy (appendix removal)_____
☐ Open cholecystectomy--gallbladder removal_____
☐ Laparoscopic. cholecystectomy _____
☐ Umbilical herniorrhaphy (belly button hernia repair)_____
☐ Inguinal herniorrhaphy (groin hernia repair)_____
☐ Ventral (abdominal) hernia surgery _____
☐ Ventral (abdominal) hernia surgery with mesh w/o mesh _____
☐ Exploratory lap. _____
☐ Gastrectomy (partial) for ulcer_____
☐ Gastrectomy (complete) for ulcers severe_____
☐ Open gastrostomy (g-t tube placement) _____
☐ Closed (percutaneous endoscopic gastrostomy) gastrostomy (g-t tube placement) _____
☐ Laparoscopic. adrenalectomy (adrenal gland removal) _____
☐ Appendectomy (appendix removal) _____
☐ Splenectomy (spleen removal) _____
☐ Hepatectomy (part of the liver removal) _____
☐ Nephrectomy (kidney removal) _____
☐ kidney transplant_____
☐ Kidney stone removal surgery_____
☐ Interstim urinary bladder stimulator placement
☐ neck surgery laminectomy fusion_____
☐ low back surgery open lumbar laminectomy with fusion
☐ mini- disc ectomy (disc removal) surgery via small incision--back surgery_____
☐ spinal cord stimulator_____
☐ Breast biopsy_____
☐ Breast lumpectomy (partial mastectomy)_____
☐ Total mastectomy_____
☐ Tubal ligation (tubes tied) _____
☐ Cesarean section_____
☐ Ovarian cyst removal_____
☐ LEEP (conization of uterine cervix)_____
☐ Myomectomy (fibroid removal)_____
☐ Partial Hysterectomy_____
☐ Total hysterectomy (removal of uterus) _____
☐ TAH-BSO (ovary tubes and uterus removal)_____
☐ Oophorectomy (ovary removal) RT or LT_____
☐ Salpingectomy (fallopian tube removal) RT or LT_____
☐ Prostatectomy, transurethral _____
☐ Prostate biopsy_____
☐ Vasectomy_____
☐ Circumcision_____
☐ Urethral dilatation _____
☐ Skin cancer surgery- excision_____
☐ Skin cancer surgery- MOH's_____
☐ Skin cancer surgery- skin graft_____
☐ Skin tissue expander placement_____
☐ Prior skin flap surgery for ulcer_____
☐ **Other**_____
☐No Surgeries /Procedures to record

Patient Signature: _____ ***DATE:*** _____

	Problem List
1	
2	
3	
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	Medicine	Dose:	Sig:	Disp:	Refills
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
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14					
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24					
25					

Refills given:

Date	Medicine	Dose:	Sig:	Disp:	Refills

REVIEW OF SYSTEMS

General

□ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble

Skin

□ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes

Head

□ Headache □ Head injury _____

Ears

□ Decreased hearing □ Ringing in ears (tinnitus) □ Earache □ Drainage

Eyes

□ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision □ Flashing lights □ Specks
□ Glaucoma □ Cataracts □ Last eye exam_____

Nose

□ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain

Throat

□ Teeth □ Gums □ Bleeding □ Dentures □ Sore tongue □ Dry mouth □ Sore throat □ Hoarseness
□ Thrush □ Non-healing sores □ Last dental exam_____

Neck

□ Lumps □ Swollen glands □ Pain □ Stiffness

Breasts

□ Lumps □ Pain □ Discharge □ Self-exams □ Breast-feeding

Respiratory

□ Cough (dry or wet, productive) □ Sputum (color and amount)□Coughing up blood (hemoptysis)
□ Shortness of breath (dyspnea) □ Wheezing □ Painful breathing

Cardiovascular

□ Chest pain or discomfort □ Tightness □ Palpitations □ Shortness of breath with activity (dyspnea)
□ Difficulty breathing lying down (orthopnea) □ Swelling (edema)

□ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal

□ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Change in bowel habits
□ Rectal bleeding □ Constipation □ Diarrhea □Yellow eyes or skin (jaundice)

Urinary

□ Frequency □ Urgency □ Burning or pain □ Blood in urine (hematuria) □ Incontinence
□ Change in urinary strength

Genital

Male- □ Pain with sex □ Hernia □ Penile discharge □ Sores □ Masses or pain □ Erectile dysfunction
□ STD's

Female- □ Pain with sex □ Vaginal dryness □ Hot flashes □ Vaginal discharge □ Itching or rash □ STD's

Vascular

□ Calf pain with walking (Claudication) □ Leg cramping Musculoskeletal- □ Muscle or joint pain
□ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma

Neurologic

□ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor

Hematologic

□ Ease of bruising □ Ease of bleeding

Endocrine

□ Head or cold intolerance □ Sweating □ Frequent urination (polyuria) □ Thirst (polydypsia)
□ Change in appetite (polyphagia)

Psychiatric □ Nervousness □ Depression □ Memory loss □ Stress

Patient Signature: _____ ***DATE :***_____

PAIN MANAGEMENT CONTRACT

I agree to adhere to the following if prescribed any controlled narcotic medication and understand that failure to do so may result in either discontinuing medication and/or immediate discharge.

- I agree to take narcotics only as prescribed.
- I agree to use only one pharmacy that will verify narcotic prescription written by all doctors.
- I agree to promptly inform the physician of any illicit drug use.
- I agree to never give or sell my narcotic medications to any other person.
- I agree to keep my narcotic medication secure from any other person.
- I will be asked for random urine, blood or hair samples to verify use, proper dose and illicit drug use.
- I agree that if my medication is stolen, I will file a police report immediately and understand no additional medication will be prescribed until the physician gets a copy of the report.
- I agree to random pill counts at any time to verify usage.
- I agree to keep all appointments unless cancelled one day in advance.
- I agree to not accept any narcotics from any other physician.
- I agree to not go the emergency room to get narcotics for chronic conditions.
- I understand medications not covered by insurance may not be prescribed.
- I understand that if my medication is lost or used up too quickly, I will not get additional medication prior to the next appointment and I may be discharged.
- I will provide written notice if I choose to terminate this agreement and doing so may result in discontinuing medication and/or discharge from practice.

I understand my rights include:

- Having the risks, benefits, side effects and alternatives to treatment explained.
- Having my pain ranked in severity on a scale, before and after treatment.
- Having the right to request for medication changes if pain persists
- Having my questions answered regarding treatment during visit.
- Having the right to refuse treatment from my physician.
- Having the right to see medical records on written request.
- Having history and physical taken
- Having pain adequately treated.

Patient Signature: _____***DATE:***_____

ADVANCE MEDICAL Home Physicians, PLC
2888 E. Long Lake Rd Suite 150 Troy, MI 48085

PHONE: (248) 250-9920 FAX back to:(248) 499-1354

MEDICAL RELEASE FORM

To: _____ Fax:_____ Pages:_____

To Whom It May Concern,
I authorize the release of my medical records to: DR. SANGITA C. PATEL.

☐ I am requesting lab reports from: LAST ADMISSION, PAST MONTH, 1 YR, 2YRS, 3YRS.

☐ I am requesting H&Ps from: LAST ADMISSION, PAST MONTH, 1 YR, 2YRS, 3YRS .

☐ I am requesting consultations from: LAST ADMISSION, PAST MONTH, 1 YR, 2YRS, 3YRS.

☐ I am requesting CT scans/MRIs from: LAST ADMISSION, PAST MONTH, 1 YR, 2YRS, 3YRS

☐ I am requesting the release all of my medical records related to all of my treatment for rendered by you or your supervision from the following date's _____ to _____.

I understand I have the right to revoke this request at any time in writing.

_____ _____ _____
PATIENT NAME (PRINTED) **DOB** **SSN**

_____ _____
PATIENT SIGNATURE **DATE OF REQUEST**

_____ _____ _____
REPRESENTATIVE SIGNATURE **RELATIONSHIP TO PATIENT** **DATE OF REQUEST**

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

Advance Medical Home Physicians
Sangita C. Patel, M.D.
2888 E. Long Lake Rd., Suite 150
Troy, MI 48085

Telephone: (248) 250-9920 Fax: (248) 250-9926

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For 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, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.