PATIENT REGISTRATION

(Please Print)

Date _____ Clinician _____

Name _____ Social Security # _____
(Last) (First) (MI)

Date of Birth:_____Age:_____ Sex: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Email Address_____

☐ Home Phone (_____) _____ ☐ Work Phone (_____) _____

☐ Mobile/Alt. Phone (_____) _____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Name of Employer (or School) _____ Grade _____

Student Status: Full-time _____ Emergency Contact name and ph. #: _____
Part-time_____

RESPONSIBLE PARTY

Responsible Party _____ Relationship to Patient _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Social Security # _____ Place of Employment _____

If other family members are seen in this office, please list: _____

***** AT THIS TIME A COPY OF YOUR CURRENT INSURANCE CARD AND PHOTO ID IS REQUESTED *****
ALTHOUGH WE TAKE A COPY OF YOUR INSURANCE CARD, WE DO REQUIRE THE FOLLOWING INFORMATION TO BE COMPLETED.

Primary Insurance Company:

Name: _____

Policy # _____ Group # _____

Subscriber Name: _____

DOB _____ SSN _____

Employer: _____

Secondary Insurance Company:

Name: _____

Policy #: _____ Group #:_____

Subscriber Name: _____

DOB: _____ SSN: _____

Employer: _____

My preference for ***automated appointment reminders*** is (please check one):

- ☐ Voice call to Home Telephone Number
- ☐ Voice call to Mobile Telephone Number
- ☐ Text Reminder to Mobile Telephone Number
- ☐ None-I do not wish to get automated reminders

_____

Signature of Patient or Legal Guardian Date

_____

Print Patient Name Print Name of Legal Guardian

PERSONAL INFORMATION

Name: _____

Referred by: _____

Previous Counseling/Treatment:

Who: _____ **Where:** _____

When: _____ **Results:** _____

Who: _____ **Where:** _____

When: _____ **Results:** _____

Nature of Current Problems:

_____

_____

Others Living in the Home:

Name: _____ **DOB:** ___/___/___ **School/Employer:** _____

Name: _____ **DOB:** ___/___/___ **School/Employer:** _____

Name: _____ **DOB:** ___/___/___ **School/Employer:** _____

Name: _____ **DOB:** ___/___/___ **School/Employer:** _____

MEDICAL INFORMATION

Primary Care Physician: _____ **Date of last visit:** _____

Address: _____ **Phone #:** _____

Medical issues: _____

Current medications: _____

Medications previously tried for current problem:

_____

Assignment of Insurance Benefits/Release of Medical Information

I authorize Partners in Counseling and Steve Nimrod to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier, prepaid medical plan or a government agency.

I request that payment be made to Partners in Counseling for any bills for service rendered to me by my provider.

I understand that I am financially responsible to my provider for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and the provider takes no responsibility for denial or delay of payment.

_____

Responsible Party's Signature Printed Name of Signee Patient Name Date

Informed Consent for Treatment

I give my consent for services for myself or my child/legal dependent with Partners in Counseling and associated members of the professional staff to include evaluation, psychotherapy, medication management, testing (if indicated) and involvement in the treatment planning process. I may at any time decline specific recommendations.

***We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities. We will suggest referral options in this event.**

_____

Responsible Party's Signature Printed Name of Signee Patient Name Date

Consent to Release Information to Primary Care Physician

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, Do_____/Do Not _____, authorize Partners in Counseling to release information related to my evaluation and treatment to:

Primary Care Physician: _____ Phone: _____

Address:

_____

(Street) (City) (State) (Zip)

_____

Responsible Party's Signature Printed Name of Signee Patient Name Date

If you would like to release medical information to another physician please request a separate release of information form from the receptionist.

Partners in Counseling, P.A.
8300 College Blvd, Suite 320
Overland Park, KS 66210

Counselor-Patient Services Agreement

I am pleased that you have selected me as your professional counselor. This document (the agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information prior to our initial session. Although these documents are long and sometimes complex, it is very important that you read them carefully before your initial session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. The revocation will be binding on me unless I have taken action in reliance on it, if there are obligations placed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

COUNSELING SERVICES: Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, counseling has also been shown to have many benefits. Counseling often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money and energy, so you should be very careful about the counselor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to provide some referrals to other counselors that may be suitable.

SESSIONS: I normally conduct an evaluation that will last from 1-2 sessions. During this time, we can both decide if I am the best person to handle the services you need in order to meet your treatment goals. If counseling is begun, I will usually schedule one appointment of 45 minutes duration per week at a time we agree upon, although some sessions may be less frequent. If I need to cancel or change an appointment time, I will attempt to give you 24-hour notice. I expect that you will also provide a 24-hour notice if you must cancel an appointment. A **$30 fee will be charged to you if you cancel without a 24-hour advance notice, unless we both agree that you were unable to attend due to circumstances beyond your control. For your convenience, you may leave a message at (931)338-0400 if you must cancel or change your scheduled appointment.**

PROFESSIONAL FEES: My hourly fee is $130.00 for the Initial Diagnostic Assessment Session. Sessions (45 minutes) thereafter will be charged at a rate of $120.00 for both individual and family counseling sessions. In addition to our scheduled appointments, I charge $100.00 per hour for other professional services you may require. Other services may include PHILE CALLS LASTING LONGER THAN 5 MINUTES, consulting with other professionals with your consent, preparation of records or treatment summaries, making requested photocopies, and the time spent performing any other services you may request. I DO NOT BECOME INVOLVED IN LEGAL PROCEEDINGS. **If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional fees including preparation and**

transportation, even if I am called to testify by another party. I charge $120.00 per hour for preparation attendance at any legal proceedings.

CONTACTING ME: I am often not immediately available by telephone. Although I am usually working between 9am and 5pm, I typically will not answer the phone. During business hours you may contact my staff at (913)338-0400. I will make every effort to return your phone call the same day, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician/psychiatrist, call 911 or go to the nearest emergency room. If you need to speak with me after normal business hours, please call (913)338-0400 and choose the option to speak to the answering service to have me contacted.

CONFIDENTIALITY: the law protects the privacy of all communication between a client and a counselor. In most circumstances, I can only release information about your treatment to others if you sign a written Authorization that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written advanced consent. Your signature on the agreement provides consent for these activities, as follows: I may at some time find it helpful to consult other health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. In turn, the other professionals are bound legally to keep information about the consultation confidential. In m practice, I work with other mental health professionals as well as with administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training bout protecting your privacy.

There are some situations where I am permitted, required or legally obligated to disclose information without consent or authorization:

- If I feel that a client may be in danger of harming themselves or someone else, I am obligated to make contact to facilities or other individuals who may provide protection.
- If I have any reason to suspect that either a child or an adult is being physically, emotionally, or sexually abused, or if someone is being neglected, exploited, or in the need of protective services, the law requires me to make contact with the appropriate governmental agency.
- If you are involved in a court proceeding, I could be court ordered to release information concerning our counseling sessions.
- If a governmental agency is requesting the information for health oversight activities, I may be required to provide information for them.
- If a client files a lawsuit against me, I may disclose relevant information regarding the client in order to defend myself.
- If you file a workers compensation claim, and I have evaluated or counseled you in regard to such claim, I must, upon appropriate request, provide a report to the client's employer or the employer's insurance company.

The laws governing confidentiality can be quite complex, so it is important that we discuss any questions or concerns you have regarding your rights of confidentiality and treatment. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS: You should be aware that pursuant to HIPAA, I keep Protected Health Information about you in one set of professional records. This set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I have received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including report to your insurance provider. Except in unusual situations that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe

that access is reasonable likely to cause substantial harm to such other person (or where information has been supplied to me by others confidentially), you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

CLIENT RIGHTS: HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosure of protected health information. These rights include requesting that I amend your record, requesting restrictions on what information from your Clinical Records is disclosed to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about my policies and procedures recorded in your records, and the right to a paper copy of this Agreement and my privacy policies and procedures. I am happy to discuss any of them with you.

MINORS AND PARENTS: Clients under 18 years of age who are not emancipated should be aware that the law may allow parents to examine their child's treatment records. Because privacy in counseling is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents, upon their request, with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child if possible and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS: You will be expected to pay each session (session fee, deductible, copay) at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, the owners of our practice might be able to negotiate a fee adjustment or payment installation plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going to small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of service provided and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits which you are entitled, however **YOU (not your health insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.**

You should carefully read the section in your insurance coverage document that describes mental health services. If you have any questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed health care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health

services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more services after a certain number of sessions. While much can be accomplished in short-term counseling, some clients feel that they need more services after insurance benefits end. Some managed care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue counseling.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. **I am required to provide a clinical diagnosis.** Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of entire clinical records. In such situations, I will make every effort to release the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this agreement, you agree that I can provide requested information to your carrier.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end sessions. It is important to remember that you always have the right to pay for my services yourself to avoid problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE DESCRIBED ABOVE.

_____ _____

Signature of Patient/Responsible Party Date Signed

_____ _____

Witness Date Signed

Partners in Counseling

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Partners in Counseling is committed to protecting your personal health information. If at any time you have any questions or concerns about how your confidential information is being used you are encouraged to notify the practice staff so that appropriate personnel can quickly address and resolve these concerns.

Effective Date: April 13, 2003
This Notice was revised on July 30, 2018.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Jane Freeman
Mailing Address:	8300 College Blvd, Suite 320, Overland Park, KS 66210
Telephone:	(913)338-0400
Fax:	(913)338-0428

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that

treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others, but we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as 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 disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

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

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are

unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization, but disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional chosen by KCPG who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with

transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an 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.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health 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. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.