NTGO
an Oncology Medical Home

Dear Patient,

We are an Oncology Medical Home (OMH) whose focus is on gynecologic cancers and complex gynecologic issues. Due to the complexity of your diagnosis, your primary care physician has referred you to us. As an OMH we keep our patients informed and involved in their care. No matter your diagnosis, we will not alter our commitment to you nor to our mission of providing quality care at the lowest cost from friendly and compassionate staff. More information about an Oncology Medical Home can be found on our website.

Prior to your first appointment, a nurse navigator will call to provide you with their name and direct phone number. In the coming days and months to follow, should you be uncertain which staff member should assist you with your question or need, your nurse navigator can always be reached to help facilitate this for you.

Included in this packet is your new patient paperwork. Please complete **all documents** prior to your appointment and arrive with these documents, your driver's license, and insurance card, no less than thirty (30) minutes prior to your appointment time. This additional time will provide the front desk the opportunity to transfer this important information into your electronic chart. Educational information, appointment information, and many of your healthcare records can be accessed through our online patient portal at www.seeyourchart.com. If you did not access your new patient paperwork through this valuable patient portal, please call and provide your nurse navigator with an email address.

NTGO has three locations. Below is a grid showing where your physician's clinics are throughout the week. Because office locations may provide different services, be sure you are certain of the location of any future appointments.

	Alan Muñoz, M.D.	Thomas Heffernan, M.D.	Arlene Garcia-Soto, M.D.	Abel Morón, M.D.
Monday	Dallas (Park Central)			Medical City of Arlington
Tuesday		Dallas (Park Central)	Presbyterian Plano	
Wednesday	Presbyterian Plano		Dallas (Park Central)	
Thursday	Dallas (Park Central)	Medical City of Plano		
Friday		Medical City of Plano		Dallas (Park Central)

Visit our website at **www.northtxgynonc.com** for location addresses

Welcome **to North Texas Gynecologic Oncology**

At your first appointment, bring:

- Driver's License
- Insurance Card
- New Patient Packet, completed

Arrive 30 minutes prior to appointment time

Patient Financial Responsibility

NTGO
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Thank you for choosing North Texas Gynecologic Oncology to serve your healthcare needs. Our physicians and staff look forward to providing excellent care to you and will work hard toward keeping the financial portion of your visit clear, up-to-date and concise. To better understand how you can assist us in accomplishing this goal, please read the information below.

1. **INSURANCE CARDS**: Please be prepared to show the receptionist your ***current*** insurance card each time you come to our office so we can verify our system contains up-to-date information.
2. **COPAYMENTS, DEDUCTIBLES and CO-INSURANCE BALANCES**: Many insurance companies require a copayment for each date of service. NTGO has a contractual obligation with your insurance company to collect this copayment. ***If your insurance plan requires you to pay a copayment, co-insurance and/or deductible, please be prepared to do so at the time of service unless other arrangements have been made.*** Once your claim is filed, the insurance company will pay the portion of the claim they are contractually obligated to pay and the balance will be the responsibility of the insured. You will receive a monthly statement showing your balance as of the date the statement was printed. If your next appointment at our office is prior to the due date, you can choose to pay your balance in our office. Alternatively, you can pay your balance by mailing us a check or using the online feature at northtxgynonc.com.
3. **CHANGES IN INSURANCE**: Insurance plans can change during the year due to employers changing plans or employees changing jobs. ***Should your insurance plan change, please contact the business office immediately. In the event you undergo chemotherapy treatment, please understand that an insurance company may take a couple of weeks to approve a treatment.*** If we are not given ample notification of a change in insurance, your treatment could be delayed or you could be financially responsible for any unpaid services.
4. **COBRA:** If you should lose your insurance and are planning on converting to a COBRA plan, please notify us immediately to avoid potential delays in your office visit, surgery or treatment.
5. **INSURANCE CORRESPONDANCE**: Information received in the mail from your insurance company should always be responded to quickly and completely. Failure to respond to an insurance inquiry may delay payment of services. Should you need help in understanding or completing the inquiries, please ask to speak with someone in our business office.
6. **Referrals and Authorizations**: Please be aware your insurance plan may require a referral or authorization for us to provide services to you. If you do not provide this information to us prior to your appointment, our office will be unable to bill your insurance company for services provided and you will be held responsible for them.
7. **PAYMENT PLANS**: If you are unable to pay your statement in full each month, a payment plan may be approved for you. If it is determined you are in need of a payment plan, please honor your payment agreement to avoid potential visit, surgery or treatment delays.
8. **MEDICARE INFORMATION AVAILABLE**: If you are eligible for Medicare, or will become eligible in the coming year, please ask someone in our business office for additional information on the benefits of enrolling in Medicare even if you and your spouse are currently working and receiving commercial insurance.
9. **ABN**: In the event your insurance company does not cover certain services recommended by our physicians, you may be requested to sign an ABN (Advanced Beneficiary Notice) and pay for these services out of pocket.
10. **UNDERSTANDING YOUR INSURANCE**: The business office will work diligently towards making the financial part of your treatment go smoothly; however, it is important for you, as the patient, to understand your policy and coverage as services not covered by your insurance are your financial responsibility.
11. **SELF-PAY**: Self-pay patients should be prepared to pay the full office visit amount, including any additional services performed during the office visit, at the time of check out.
12. **RETURN CHECK FEE**: A $25.00 return check fee will be added to your balance for any non-paid payment received.
13. **REFUNDS**: Refunds are issued when an overpayment has been identified. If you feel a refund is due, please contact us.

By signing below, you indicate you have been made aware of your financial responsibilities.

_____ _____ _____

PATIENT NAME PATIENT SIGNATURE DATE

_____ _____

STAFF INITIALS DATE

Authorization for Release of Information

NTGO
an Oncology Medical Home

Patient Name _____ **Date of Birth** _____

I hereby authorize NTGO to release copies of my medical records to _____ .

I hereby authorize _____ to release information and my medical records to NTGO.

Restrictions: (none if left blank)

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the information to be released contains any information about HIV/AIDS, an additional HIPAA release of medical information may be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.

Communication Preferences

(Indicate all that apply)

	Leave message with **detailed information**	Leave message with **call-back number only**
Home Phone	☐	☐
Cell Phone	☐	☐
Work Phone	☐	☐

_____ _____

Patient / Representative Signature Today's Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____

Relationship To Patient

North Texas Gynecologic Oncology

12200 Park Central Drive, Suite 410, Dallas, Texas 75251

p 972.490.5970 | *f* 972.490.5632 | www.northtxgynonc.com

Alan K Munoz, MD
Thomas P Heffernan, MD
Arlene E Garcia-Soto, MD
Abel Morón, MD

MEDICAL HISTORY

NTGO
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PATIENT NAME _____ **DATE OF BIRTH** _____

☐ **New Patient** ☐ **Established Patient Update** **TODAY'S DATE**_____

PAST MEDICAL HISTORY — *Indicate any of the following that apply*

☐ Underactive Thyroid (Hypothyroidism)	☐ High Cholesterol (Hyperlipidemia)	☐ Diabetes	☐ Coronary Artery Disease
☐ Heart Attack (Myocardial Infarction)	☐ Peripheral Vascular Disease	☐ Congestive Heart Failure	☐ Atrial Fibrillation
☐ Deep Vein Thrombosis	☐ Pulmonary Embolism	☐ High Blood Pressure (Hypertension)	☐ COPD
☐ Asthma	☐ Osteoporosis	☐ Lumbar Disk Disease	☐ Frequent Urinary Infections
☐ Renal Failure ☐ Dialysis	☐ Kidney Stones	☐ Upper or Lower GI Bleed	☐ Fibrocystic Breast Disease
☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Irritable Bowel Syndrome	☐ Cirrhosis
☐ Hepatitis	☐ Seizure Disorder	☐ CVA (Stroke)	☐ TIA (Transient Ischemic Attack)
☐ Peripheral Neuropathy	☐ Depression	☐ Schizophrenia	☐ Bipolar Disorder
☐ Rheumatoid Arthritis	☐ Auto Immune Disorder(s) _____		☐ HIV / AIDS
☐ HPV	☐ Herpes	☐ Gonorrhea / Chlamydia	☐ Syphilis

GENETIC TESTING? Have you or a family member ever had Genetic Testing? ☐ Yes ☐ No

If yes, please complete type of test: BRCA ☐ Positive ☐ Negative

Lynch Syndrome ☐ Positive ☐ Negative

PAST SURGICAL HISTORY — *Indicate any of the following surgeries that apply*

☐ Tonsillectomy	☐ Adenoidectomy	☐ Cataract Surgery	☐ Thyroidectomy
☐ Cervical Disk Fusion	☐ Pacemaker Insertion	☐ Coronary Bypass Stenting	☐ Coronary Artery Bypass Graft
☐ Exploratory Laparotomy	☐ Exploratory Laparoscopy	☐ Appendectomy	☐ Gallbladder Removal (Cholecystectomy)
☐ Removal Spleen (Splenectomy)	☐ Stomach Removal (Partial Gastrectomy)	☐ Surgery for Aneurysm (Aneurysmectomy)	☐ Femoro-Popliteal Bypass
☐ Varicose Vein Stripping	☐ Inguinal Hernia Repair (Inguinal Herniorraphy)	☐ Ventral Hernia Repair (Ventral Herniorraphy)	☐ Hemorrhoidectomy
☐ Hysterectomy – partial, ovaries were NOT removed (ovarian preservation)	☐ Hysterectomy – total, ovaries WERE removed (salpingo oophorectomy)	☐ C-Section	☐ Tubal Ligation (tubes tied)
☐ Organ Transplant	☐ Other:		

PAST CANCER HISTORY — *Indicate any of the following cancers that apply*

☐ None ☐ Breast ☐ Cervix ☐ Ovaries ☐ Uterus ☐ Colon ☐ Lung ☐ Other:

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY

Age of first menstrual period: _____

Age of Menopause (if applicable): _____

Date of Last Menstrual Period: _____

Describe your periods:
☐ Regular
☐ Irregular

Menstrual flow is (was) typically:
☐ Light
☐ Normal
☐ Heavy

HORMONE THERAPY

☐ Never ☐ Current ☐ Previous (date stopped): _____

Number of years used? _____ Type: _____

PATIENT NAME _____ **DATE** _____

CONTRACEPTIVE (birth control)

Oral Contraceptive Methods:

☐ Never ☐ Current ☐ Previous (date stopped): _____

Number of years used? _____ Type: _____

Other Contraceptive Methods: (not including Condoms)

☐ Never ☐ Current ☐ Previous (date stopped): _____

Number of years used? _____ Type: _____

MATERNITY

Number of Pregnancies _____ Number of Births _____ Age at first full-term pregnancy _____

HYSTERECTOMY

Have you had a hysterectomy: ☐ Yes ☐ No *If answered Yes*: Do you have ☐ One *or* ☐ Both ovaries?

Do you still have a cervix? ☐ Yes ☐ No ☐ Unsure

SOCIAL HISTORY

BLOOD TRANSFUSIONS If necessary, will you accept blood during surgery? ☐ Yes ☐ No

TOBACCO use ☐ Never ☐ Current Every day smoker ☐ Current Some Day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Pipe smoker ☐ Chew Tobacco ☐ Moist powdered tobacco ☐ Snuff ☐ E-cigarettes ☐ Former smoker ☐ Previous (date stopped): _____ Number of years used? _____ # packs per day: _____

ALCOHOL use ☐ Never ☐ Occasionally ☐ Previous Number of years? _____

On average, how many drinks per: Day _____ Week _____ Type: ☐ Wine ☐ Beer ☐ Spirits

DRUG use *Do you use illicit drugs?* ☐ Yes ☐ No Type:_____

MARITAL STATUS ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

CHILDREN ☐ No Children ☐ Yes, I have _____ living children

Your OCCUPATION ☐ Retired ☐ Homemaker ☐ Other: _____

FAMILY MEDICAL HISTORY

Mother ☐ Alive, age _____ ☐ Deceased at age _____, cause of death: _____

Father ☐ Alive, age _____ ☐ Deceased at age _____, cause of death: _____

Siblings *Number of:* Living Brothers: ____ Living Sisters: _____ Deceased Siblings: _____

FAMILY CANCER HISTORY

☐ None ☐ Unknown ☐ Breast ☐ Ovarian ☐ Lung ☐ Pancreatic ☐ Colon ☐ Prostate ☐ Thyroid ☐ Melanoma ☐ Neurofibromatosis ☐ Familia Adenomatous Polyposis (FAP) ☐ Other:

FAMILY DISEASE HISTORY

☐ None ☐ Unknown ☐ High Blood Pressure (Hypertension) ☐ Diabetes ☐ Coronary Artery Disease ☐ High Cholesterol (Hyperlipidemia) ☐ Other:

HEALTH MAINTENANCE HISTORY

Colonoscopy ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Mammogram ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Pap Smear ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Have you had a Flu vaccine this year? ☐ NO ☐ YES (date) _____

Have you had a Pneumonia vaccine this year? ☐ NO ☐ YES (date) _____

Have you had the Gardasil vaccine series? ☐ NO ☐ YES (dates) _____ _____ _____

PATIENT NAME _____ **DATE** _____

DRUG ALLERGIES — *list any medication allergies below*

	Medication	Reaction
1.		
2.		
3.		

FOOD ALLERGIES — *list any food allergies below*

	Food	Reaction
1.		
2.		
3.		

MEDICATIONS — *list all medications you are currently taking including supplements*

	Name of Drug	Dosage Amount	Frequency Taken
1.		mg or mcg	#____taken_____ times daily or every _____ hours
2.		mg or mcg	#____taken_____ times daily or every _____ hours
3.		mg or mcg	#____taken_____ times daily or every _____ hours
4.		mg or mcg	#____taken_____ times daily or every _____ hours
5.		mg or mcg	#____taken_____ times daily or every _____ hours
6.		mg or mcg	#____taken_____ times daily or every _____ hours
7.		mg or mcg	#____taken_____ times daily or every _____ hours
8.		mg or mcg	#____taken_____ times daily or every _____ hours
9.		mg or mcg	#____taken_____ times daily or every _____ hours
10.		mg or mcg	#____taken_____ times daily or every _____ hours

PHARMACY — *Complete all information of your pharmacy*

Pharmacy Name	Address	Phone#
_____	_____	_____
	_____	

FAMILY HISTORY QUESTIONNAIRE

for Common Hereditary Cancer Syndromes

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PATIENT NAME _____ **DATE OF BIRTH** _____

PATIENT SIGNATURE _____ **TODAY'S DATE** _____

Age at first period_____ Age at first full term pregnancy_____
Have you had a surgical or needle biopsy of the breast? YES NO
If yes, did the biopsy show atypical cells? YES NO UNKNOWN
Are you menopausal? YES NO
Have you ever used Hormone Replacement Therapy? YES NO
Has anyone in your family had genetic testing for a hereditary cancer syndrome? YES NO

Please mark below if there is a PERSONAL or FAMILY history of any of the following cancers. If yes, then indicate family relationship AND age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles and cousin.

BREAST AND OVARIAN CANCER (BRCA)

			YOU (age of diagnosis)	Siblings/Children (age of diagnosis)	Mother's side (age of diagnosis)	Fathers side (age of diagnosis)
YES	NO	*Example: Colon Cancer*		*Brother at 36*	*Aunt at 44*	*Grandfather at 65 Cousin at 58*
☐	☐	Breast Cancer				
☐	☐	If yes above, was Tamoxifen or Herceptin prescribed?				
☐	☐	Breast cancer in both breasts or multiple primary breast cancers				
☐	☐	Ovarian Cancer				
☐	☐	Male Breast Cancer				
☐	☐	Prostate Cancer (BRCA)				
☐	☐	Pancreatic Cancer (Col/BRCA)				
☐	☐	Melanoma (BRCA)				
☐	☐	Are you of Ashkenazi Jewish decent?				

COLON and UTERINE CANCER (Colaris)

☐	☐	Uterine (endometrial) Cancer				
☐	☐	Colon Cancer				
☐	☐	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer. (Please circle type of cancer)				
☐	☐	Pancreatic Cancer (Col/BRCA)				

For Office Use Only:

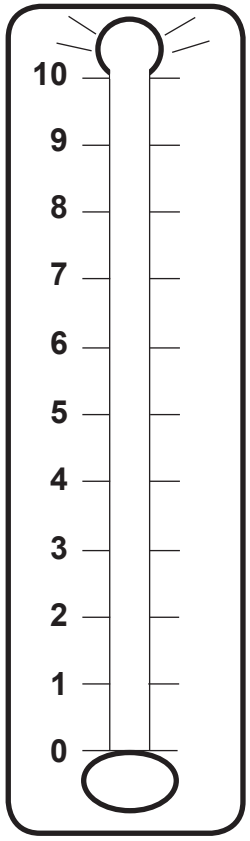
Confirmed Triple Negative Status	YES	NO		
Patient meets NCCN criteria for testing	YES	NO		
Patient offered hereditary cancer testing	YES	NO	If Yes: accepted declined	Reason:
Follow-up appointment scheduled	YES	NO	Appt Date:	
Health Care Provider's Signature				Date:

Distress Thermometer

Name _____ **Date of Birth** _____

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the *past week including today*.

Extreme distress



No distress

Indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities

		Spiritual/religious concerns
❑	❑	

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

Notice of Privacy Practices

North Texas Gynecologic Oncology

Alan K Munoz, MD *Thomas P Heffernan, MD* *Arlene E Garcia-Soto, MD* *Abel Morón, MD*

NTGO
an Oncology Medical Home

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information 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 Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our

business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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 Health 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.

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 Health Information in response to a court or administrative order. We also may disclose Health Information 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 Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information 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 Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if 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

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 practically can do so.

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. Uses and disclosures of Protected Health Information for marketing purposes; and
2. 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:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. 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 of 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 who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

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 Amend. If you feel that 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 our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. 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 agree, we will comply with your request unless the information is needed to provide you with 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 about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.