House Calls Atlanta, LLC™
Alison A. Schlenger, MSN, MSW, GNP-BC
Gerontological Nurse Practitioner/Clinical Manager
1960 Annwicks Drive Marietta, GA 30062
Cell: 404-333-3316 Fax: 1-678-530-1054
housecallsatlanta@gmail.com

Welcome to House Calls Atlanta, LLC™. We are honored to be a part of your healthcare team, and are committed to providing you (or your loved one) with quality in-home medical services. We understand that it can often be difficult for many older adults to be seen by their primary care provider on a timely basis. House Calls Atlanta is **NOT** an emergency medical service. **For medical emergencies, patients must call 911.**

A visit by a House Calls Atlanta, LLC™ gerontological nurse practitioner can help to relieve the burden for both patients and their caregivers when there is an acute medical need. By addressing these acute illnesses in a timely manner, unnecessary trips to the emergency room can be avoided. Our nurse practitioners can also provide management of chronic illnesses and ease the transition from hospital stays back to the home.

House Calls Atlanta, LLC™ care is guided by our core values including:

- We treat the *whole* patient
- We provide medical care that allows patients to maintain their dignity
- We are dedicated to quality of life including advocacy and service coordination
- We provide preventative care by delivering *proactive* care thus preventing unnecessary hospitalizations
- We provide cost-effective, high quality care by reducing unnecessary visits to the emergency department and/or protracted hospital stays

Our nurse practitioners will share their expertise with you (or your loved one) with the goal of improving quality of life, preserving functional status, and optimizing health. We are looking forward to working with you as part of your healthcare team. Please contact us whenever you'd like to talk about anything you think may be affecting your (or your loved one's) health.

Enclosed in this packet are a set of registration materials that should be completed and returned to us via fax, mail, or email. Once we receive this information, we will call you to schedule an appointment. Please do not hesitate to call us if you should have any questions.

Sincerely,

Alison A. Schlenger, MSN, MSW, GNP-BC
Founder/Nurse Practitioner

Enclosures:

1. Demographic Intake Form
2. Medical History Form
3. Consent to Treatment/Assignment of Benefits/Medical Information Disclosure/Payment Agreement Form
4. Referring Physician/Authorization to Release Medical Information
5. Notice of Privacy Practices

HOUSE CALLS ATLANTA, LLC™
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Demographic Intake Form

House Calls Atlanta
Date of Intake: _____ Account # _____ HCA Provider: _____
1st Visit Date: _____

PATIENT INFORMATION
Name: _____
Street: _____
Facility/Complex: _____Room #____
Town/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Other Phone: _____

Date of Birth: _____/_____/_____
Sex: M F
Soc Sec Number: _____-_____-_____

EMERGENCY CONTACT INFORMATION
Name: _____
Phone: _____
Relationship to Patient:_____
Contact you with Visits/Times: **Yes or No**

Name: _____
Phone: _____
Relationship to Patient:_____
Contact you with Visits/Times: **Yes or No**

RESPONSIBLE PARTY INFORMATION
(Billing Address)
Name: _____
Street: _____
Town/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Relationship to Patient: _____

_____***CHIEF COMPLAINT***
Is patient a diabetic? _____
Has patient been in the hospital in the past 3 months? _____
If so, what hospital:_____
If so, when was hospital stay:_____
Current health concerns:_____
_____
_____
_____

PRIMARY INSURANCE
Insurance Company: _____
Claim Address: _____
City/State/Zip: _____
Group Number: _____
Policy/ID Number: _____
Name on Card: _____
Date of Birth: _____
Soc Sec Number: _____

SECONDARY INSURANCE
Insurance Company: _____
Claim Address: _____
City/State/Zip: _____
Group Number: _____
Policy/ID Number: _____
Name on Card: _____
Date of Birth: _____
Soc Sec Number: _____

PRIMARY PHYSICIAN
Name:_____
Phone: _____
Fax: _____

OTHER PHYSICIANS
Name:_____
Phone: _____
Fax: _____
Specialty: _____

Name:_____
Phone: _____
Fax: _____
Specialty: _____

OTHER INFO
How did you hear about House Calls Atlanta?
_____
Do you receive Home Health services? Yes No
Agency: _____
Phone: _____
Who is calling in this referral? Name: _____
Phone: _____Fax: _____

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Medical History Form

Name: _____ Birth date: ___/___/____ Date: ___/___/____

Person filling out form: _____ Relationship: _____

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible for our patients. Feel free to use additional pages to write any information no included here that you think is important.

Main reason for visit: _____
_____

1. **Current/Past Medical Problems:** Example—Strokes, Heart Trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye Problems, etc.

Current or Past Medical Problem	Approximate date of onset of diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	

2. **Past Surgeries:** Example---Gall Bladder removal, Appendectomy, Hysterectomy with or without ovaries removed, cataract surgery, prostate surgery, heart surgery, angioplasty, colonoscopy, etc.

Past Surgery	Approximate date of surgery
1.	
2.	
3.	

3. **Medical Allergies and reaction:** Example---rash, swelling, trouble breathing, etc.

Name of Medication Causing Allergy	Reaction
1.	
2.	
3.	
4.	

4. **Medications: Please list both prescription and over the counter medications** (such as pain relievers, constipation medicine, heartburn medicine, vitamins, etc.) and how many times a day medication is taken. For as needed medication, please give an estimate of how often you take it such as once every other day, once a week, once or twice a month, etc. Add another sheet with additional medications if necessary.

Medications and Strength (mg or mcg, etc.)	How Often Taken or As Needed
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

5. **Local Pharmacy:** _____ **Phone #:** _____
   Mail Order Pharmacy: _____ **Phone #:** _____
   Member ID #: _____ **Fax#:** _____

6. **Family History:** Please list medical problems of close family members (example—dementia, cancer (and what type), heart disease, stroke, hypertension, depression, etc.), if anyone has died, the age of death and the cause of death.

Family Member	Age Died	Cause of Death/Medical Problems
Father		
Mother		
Brother		
Sister		
Children		
Children		

7. **Social History:**
   - **Tobacco Use:** ☐ Never ☐ Quit ☐ Current Smoker
     Packs per day on average: _____ Years smoked: _____ Quit Date: _____
     Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chewing
   - **Alcohol Use:** ☐ None Number of drinks per week _____
     Was drinking too much alcohol ever a problem for you ☐ Yes ☐ No
   - **Illegal Drug Use:** ☐ No ☐ Yes Type: _____
   - **Sexual Activity:** ☐ Not Currently ☐ No ☐ Yes

- Describe who cares for patient: _____
- Tell us something the patient is proud of in their lifetime: _____
  _____
  _____
  _____
- **Past Occupation**: _____ **Years of Education**: _____
- **Advance Directives:** ☐ Durable Power of Attorney for Healthcare (DPOA)
  ☐ Name and Relationship of DPOA: _____
  ☐ Living Will ☐ Do Not Resuscitate Form
  Would you like information on Advance Directives? ☐ Yes ☐ No
  If you have any of the above documents, please have a copy of them made for us to place in your chart.
- **Religion/Faith**: _____ Is your faith important to you and does it affect your health care decisions: _____

8. **Activities of Daily Living:** Please mark or fill in the appropriate box below.

Activities of Daily Living	No Assistance	Total Assistance	Needs Some Partial Assistance: Please Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

9. **Medicare Home Health Agency**: ☐ Yes ☐ No Name: _____
   Phone #: _____ Nurse: ☐ Yes ☐ No
   Physical Therapy: ☐ Yes ☐ No Occupational Therapy: ☐ Yes ☐ No

10. **Review of Systems:** Please check or describe below any of the following symptoms you may be having:
    - **General:** ☐ Fever ☐ Chills ☐ Weight Loss ☐ Fatigue ☐ Sweating ☐ Weakness
    - **Height:** _____Feet _____Inches Any loss of height _____inches
    - **Weight:** _____pounds(can estimate) Please list weight loss _____pounds over the past _____ months
    - **Skin:** ☐ Rash Location: _____ ☐ Itching ☐ Bedsores
      Location of bedsore(s) and type of dressing: _____
    - **Head:** ☐ Headaches ☐ Hearing loss ☐ Hearing aid ☐ Ringing in ears ☐ Ear pain
      ☐ Ear discharge ☐ Nose bleeds ☐ Nose congestion ☐ Sore throat
      ☐ Last dental exam: _____
    - **Eyes:** ☐ Blurred vision ☐ Double vision ☐ Light sensitivity ☐ Eye pain
      ☐ Eye discharge ☐ Eye redness ☐ Last eye exam: _____

- **Heart:** ☐ Chest pain ☐ Palpitations ☐ Trouble breathing lying flat ☐ Leg cramps ☐ Leg swelling
- **Lungs:** ☐ Cough ☐ Sputum production ☐ Shortness of breath ☐ Wheezing ☐ On Oxygen Oxygen Flow Rate: _____
- **Gastrointestinal:** ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Incontinence
- **Genitourinary:** ☐ Urinary burning ☐ Urgency ☐ Frequency ☐ Blood in urine ☐ Incontinence
- **Musculoskeletal:** ☐ Muscle aches ☐ Neck pain ☐ Back pain ☐ Joint pain Location of joint pain: _____ ☐ Falls
- **Endocrine:** ☐ Easy bruising ☐ Environmental allergies ☐ Extreme thirst If diabetic, AM blood sugar range: _____PM blood sugar range: _____
- **Neurological:** ☐ Dizziness ☐ Tingling ☐ Tremor ☐ Sensory change ☐ Speech change ☐ Difficult/Trouble swallowing ☐ Weakness on one side of body from stroke ☐ Seizures ☐ Loss of consciousness
- **Psychiatric:** ☐ Depression ☐ Suicidal thoughts ☐ Anxiety ☐ Substance abuse ☐ Hallucinations ☐ Nervous/Anxious ☐ Insomnia ☐ Memory loss

11. **Immunizations:** Please mark the appropriate box below and list dates if known. **If not known, please contact your primary care doctor before our visit and ask if you are up-to-date on your immunizations.**

Immunization	Yes	Date	No	Unknown	Refuses
Influenza (Flu)					
Pneumococcal (Pneumonia)					
Zoster (Shingles)					

12. **Durable Medical Equipment:** Please list any medical equipment you have in the home such as a bedside commode, wheelchair, walker, hospital bed, tube feeding pump, suction machine, etc. Please list the name of the medical supplier and their phone number.

Name of Equipment	Supplier Name	Supplier Phone #
1.		
2.		
3.		
4.		
5.		

13. Recent Hospitalization: Please list the reason for any recent hospitalizations in the past 2 years and the hospital you were in.

Reason for hospitalization	Name of Hospital	Dates of Hospitalization
1.		
2.		
3.		
4.		
5.		

14. Recent doctors: Please list any recent doctors, their specialty (e.g. family practice, internal medicine, cardiology, neurology, etc.) and their phone number and fax number.

Doctor Name	Specialty	Phone #	Fax #
1.			
2.			
3.			
4.			

Please return this information to House Calls Atlanta using one of these methods prior to the first visit:

Mail: House Calls Atlanta, 1960 Annwicks Drive, Marietta, GA 30062

Fax: 1-678-530-1054 (must dial "1")

Email: housecallsatlanta@gmail.com

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Patient Name: _____ Account #: _____

CONSENT FOR TREATMENT

Initials: ____I acknowledge and understand that, in presenting myself for treatment and continuing medical care with House Calls Atlanta, LLC™, that I authorize and consent to the administration and performance of all tests, treatments, or procedures (including emergency or life-saving measures) which may be ordered by the providers of House Calls Atlanta, LLC™.

ASSIGNMENT OF BENEFITS

Initials: ___ I authorize payment of medical benefits to House Calls Atlanta, LLC™, the undersigned provider or supplier for medical services, to include government assigned benefits. I also authorize the release of any medical or other information from my medical record necessary to process a claim for payment on my behalf.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Initials:____ I hereby acknowledge that I have received the HIPAA Notice of Privacy Practices for Personal Health Information. I understand that I may obtain a copy of any future revised notices from House Calls Atlanta, LLC™ by contacting the office.

FINANCIAL AGREEMENT

Initials: _____I hereby agree that I am financially responsible for charges incurred at the time of rendered services. All deductibles and co-pays are due upon receipt of statement. Should my account be referred to an attorney or agency for the collection, the undersigned shall pay reasonable attorney fees and collection expenses.

Patient Signature: _____
OR

Patient Representative Signature: _____
Print Name/Relationship: _____

Date: _____

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REFERRING PHYSICIAN INFORMATION SHEET

Please complete the following information on every provider (Physician and/or Nurse Practitioner) that has treated you in the past three years:

Provider Name: _____
Address: _____
_____
Phone#: _____

Provider Name: _____
Address: _____
_____
Phone#: _____

Provider Name: _____
Address: _____
_____
Phone#: _____

Provider Name: _____
Address: _____
_____
Phone#: _____

Provider Name: _____
Address: _____
_____
Phone#: _____

Provider Name: _____
Address: _____
_____
Phone#: _____

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Authorization to Disclose Information for Purposes Requested by Patient or Physician's Office

I, _____, hereby authorize **House Calls Atlanta, LLC™** to disclose protected health information to the aforementioned providers for medical reasons. This information may include but is not limited to letters which may discuss my visit, treatment plan, and progress or copies of visit notes, lab reports, diagnostic reports, or other communication such as phone calls which may be deemed necessary to provide effective communication between the various providers involved in my healthcare.

This authorization shall be in force and in effect until _____at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Privacy Officer** at 1960 Annwicks Drive, Marietta, GA 30062. I understand that a revocation is not effective to the extent that **House Calls Atlanta, LLC™** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

House Calls Atlanta, LLC™ will not condition my treatment, payment, or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state or federal law.
- Refuse to sign this authorization.

The use or disclosure under this authorization to the providers involved in my healthcare will not result in direct or indirect remuneration to **House Calls Atlanta, LLC™** from a third party.

_____ _____
Signature of Patient or Personal Representative Name of Patient or Personal Representative (please print)

_____ _____
Date of Birth Relationship to Patient (or other authority to serve)

_____
Date

House Calls Atlanta, LLC™
Alison A. Schlenger, MSN, MSW, GNP-BC
Gerontological Nurse Practitioner
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Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to this information. Please review this notice carefully.

If you have any questions about this notice, please contact Alison Schlenger, Privacy Officer.

WHO WILL FOLLOW THIS NOTICE

This notice describes House Calls Atlanta's procedures and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments and units of House Calls Atlanta.
- Any member of a volunteer group we allow to help you while you are in our practice.
- All employees, staff and other practice personnel.

A. Our commitment to your privacy:

House Calls Atlanta ("our practice") is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you, as well as records regarding payment for those services. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have any questions about this Notice, please contact our office.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including but not limited to, our doctors, nurses, and nurse practitioners—may disclose your PHI in order to treat you or assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your PHI to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for your benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collections efforts.
3. **Health care operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care or who assists you in taking care of you. For example, a parent or a guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
8. **Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health oversight activities**. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and similar proceedings**. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law enforcement.** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices'
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive, or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator(s).

5. **Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Organ and tissue donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research.** Our practice may use and disclose your PHI for research purposes to certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver or your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure, (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law): and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required as law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
(B) The research could not practicably be conducted without the waiver;
(C) The research could not practicably be conducted without access to and use of the PHI.

8. **Serious threat to health or safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosures for these purposes would be necessary:
(a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or
(c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' compensation**. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting restriction.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends.

We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes, You must submit your request in writing to in order to inspect and /or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may require a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of disclosures**. All of our patients have the right to request an "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. Use of your PHIas part of the routine patient care in our practice is not required to be documented—for example, the doctor sharing information with the nurse; or the nurse practitioner; or the billing department using your information to file your insurance claim. In order toobtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14,2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a paper copy of this notice.** You are entitled to a paper copy of our notice of privacy practice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our office.
7. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding theuse and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our office.