APPLEGATE MEDICAL ASSOCIATES

689 E 19th Ave
Eugene, OR 97401

PHONE 541-868-1876
FAX 541-868-0932

PATIENT REGISTRATION

Patient Name _____ Birthdate _____

Sex M F Marital Status M W D S

Street Address _____ Mailing Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ (Work/Other) _____

Social Security Number _____ Employer _____

Primary Physician _____ Who referred you? _____

Person to contact in emergency _____ EmergencyTelephone _____

Preferred Pharmacy _____ Special Needs _____

Responsible Party (Person responsible for payment) Self Spouse Parent Other

Name of Responsible Party if other than Self) _____

Address: _____

City _____ State: _____ Zip Code: _____

Primary Medical Insurance: _____ Insured party: Self Spouse Parent Other

ID# _____ SocSec# _____ Group/Plan # _____

Name of Insured (if other than Self) _____

Ins. Address: _____ City _____ State _____ Zip Code _____

Secondary Medical Insurance: _____

Insured party: Self Spouse Parent Other ID# / SocSec# _____ Group/Plan# _____

Name of Insured (if other than Self): _____

Ins. Address _____ City _____ State _____ Zip Code _____

PERMISSION TO RELEASE INFORMATION & ASSIGNMENT

I hereby authorize Applegate Medical Associates to furnish to the insurance company or other payer, or their representatives, or either myself or the subscriber, or to the referring physician all medical or financial information which may be requested concerning the patient's present illness, injury or condition.. I hereby authorize my insurance benefits be paid directly to Applegate Medical Associates, and I understand that I am financially responsible for non-covered services. I understand that it is my responsibility to determine if my physician is a member of my insurance plan.

_____ _____ _____

Patient Signature Parent/Guardian Signature Date

_____ _____ _____

Patient Signature Parent/Guardian Signature Date

Please initial rec'd Privacy Policy _____ OR Refused Privacy Policy _____

HAVE YOU HAD:	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Head injury w/unconsciousness			Sexually Transmitted Disease			Counseling/Mental Health Treatment		
Asthma			Chicken Pox			Recreational Drug Use		
Recurrent Headaches			Scarlet Fever			Tobacco Use		
Seizure Disorder			Hay Fever			Alcohol Use		
Hearing Loss			Rheumatic Fever			# times per week		
Recurrent Ear Infections			High Cholesterol			Amount per session		
Thyroid Problem			Hepatitis A,B or C			Exercise: # times per week		
Heart Problem/Murmur			Diabetes			Operations/Dates:		
Kidney/Urinary Tract Problems			High Blood Pressure					
Gynecology Problems			Digestive Tract Problem					
Recent Weight Change			Cancer/Tumor/Cyst			Chronic Health Problems:		
Bleeding/Blood Disorder			Eating Disorder					
Tuberculosis								

ALLERGIES or REACTIONS TO MEDICINES:_____

When were your most recent **IMMUNIZATIONS:**

Hepatitis A_____ Hepatitis B____ Influenza (flu shot)_____ Measles_____ Pneumovax (Pneumovax)_____

Rubella_____ Tetanus (Td)_____ Varicella (chicken pox)_____ or Illness_____

When were your most recent **HEALTH MAINTENANCE** screening tests:

Mammogram (year)_____ Normal?_____ PSA (Prostate Cancer Screen)_____ Normal?_____

Pap Smear (year)_____ Normal?_____ Stool Test for Blood_____ Normal?_____

Sigmoidoscopy_____ Normal?_____

HAS ANY FAMILY MEMBER EVER HAD:

(parent, sibling or grandparent)	YES	NO	Relationship:	(parent, sibling or grandparent)	YES	NO	Relationship:
Tuberculosis				Asthma			
Drug/Alcohol Abuse				Thyroid Disease			
Diabetes				Seizure Disorder			
Kidney Disease				Blood Disorder			
Heart Disease				Cancer			
High Blood Pressure				Stroke			
Arthritis				Obesity			
Stomach Disease				Other:			
High Cholesterol							

Family Member	**Health Status** Excellent/Average/Poor	**Age**	**If no longer living, cause of death & age at death**
Father			
Mother			
Brothers			
Sisters			
Spouse/Partner			
Children			

APPLEGATE MEDICAL ASSOCIATES, LLP
689 E 19th Ave
Eugene, OR 97401
(541)868-1876

Information Relating to Our Practice

1. Our regular office hours are 8:00 am to 5:00 pm daily.
2. Because of the high volume of incoming morning phone calls, the best hours to call are after 10:00 am and before 3:00 pm.
3. Please bring all current medications with you to each appointment. This will aid your physician in evaluating your medication use.
4. For prescription refills:
    a. Please call the pharmacy where you get your medications several days before you will run out.
    b. The pharmacy will fax us with the name of the medication, dosage and directions. Your physician will review the prescription and the nurse will fax the pharmacy back. Be aware this process may take up to 72 hours.
    c. Please do not call our clinic for refills unless you need a written prescription.
    d. Friday afternoon requests will be sent to the pharmacy on Monday morning.
5. If you receive injections on a regular basis, please call to schedule a nurse appointment.
6. If you have lab work done following your appointment, remember that it will take a few days for the results to return. If any of the results are abnormal. Your physician or his nurse will notify you. Otherwise, we will discuss the results at your next appointment. Lab information may be sent by mail.
7. If you are calling the clinic for a referral to a specialist, please provide the following information:
    a. Your insurance carrier
    b. Complete name of the physician to whom you re being referred.
    c. Specific problem/diagnosis
    d. Date of appointment if already scheduled.
8. If you have been waiting more than a week to get an appointment with a specialist or hear if a referral has been approved, please call our office at (541)868-1876. We will try to locate the source of the delay for you.
9. In consideration of the schedule for all patients, please try to be on time for your appointment. Please reschedule if you find you are more than 15 minutes late. A 24 hour notice of cancellation is also appreciated since we may be able to accommodate another patient in urgent need. Patient appointments are scheduled for a designated amount of time. **In consideration of other patients, it may not be possible to address all of your concerns in one appointment. If you have numerous concerns or health issues to discuss with your physician, it may require that a follow up appointment be made. Thank you for your understanding.**
10. **Please be aware that if you have three no shows or cancellations in a row, our policy is to dismiss you from our practice. Please notify us 24 hours in advance if you are unable to make your appointment. We will make every attempt to make reminder calls the day before your appointment. Please call to confirm your appointment if you have not heard from us.**
11. If you have an urgent need to see the doctor, please call (541)868-1876 before coming to the clinic. This will allow us to accommodate your needs efficiently.
12. Please call your insurance company before coming in for special appointments, like a procedure. Your insurance company can tell you if the appointment will be covered by insurance and how much they are willing to pay.

Applegate Medical Associates, LLP

John V. Allcott, M.D. Katelyn Kirchheimer, FNP-C Henry Elder, M.D.

Request for Confidential Communication and/or Restriction on Use/Disclosure of Medical Information

Patient Name: _____ **DOB:** _____

Address: _____
Street Address City State Zip

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

I authorize Applegate Medical Associates to communicate my confidential health information to:

_____

_____

_____

Any information_____ Information only regarding the following: _____
Initials

_____

Applegate Medical Associates normally communicates with patients via mail, phone and fax. We do not leave confidential information on an answering machine. If you desire an alternative method of communication, please list your specific instructions: _____

_____

****

I request restriction on communication of the following information, to any source, or to a specific source without my written authorization unless the communication is required for emergency care:

_____

_____

****

To our patients: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree with your requested restriction. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communication if medical information by alternative locations only if you (1) specify the alternative location, address or telephone number and/or the alternative means of contact, and (2) agree to be responsible for and explain how payment can be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that understand and agree to the above information.

Patient Signature _____ Date _____

_____Request of Communication Confidentiality Accepted _____Request of Communication Confidentiality Denied

Reason for Denial _____

_____Request of Restriction Accepted _____Request of Restriction Denied

Reason for Denial _____

This Restriction and Confidentiality Communication Form will be made part of the above named patients medical record

Applegate Medical Associates
689 E 19th Ave
Eugene, OR 97401
Phone: 541-868-1876 Fax: 541-868-0932

Please return a copy of this patient authorization with the attached records.

Patient Name: _____ Other Names Used: _____

Date of Birth: _____ Phone Number: _____

1. Purpose of Release Request:

☐Transfer of Care ☐Moving/Relocation outside area ☐Specialist ☐Self-Use
☐Legal Reasons ☐Doctor Consultation/Referral ☐Other: _____

2. Type of General Medical Information to be released:

☐ **ALL** Physician notes and records limited to two years of information and excludes other protected records
☐ Lab test results. Please specify tests and their date_____
☐ Imaging reports (MRI, X-ray, CT, etc....) Please specify their dates_____
☐ Electrocardiogram (ECG/EKG) Reports
☐ Visit/Encounter Notes
☐ Immunization Records
☐ Diagnosis List
☐ Vaccine and Medication Record
☐ Problem List
☐ Operative Report
☐ Health Information Summary
☐ List of Allergies
☐ Billing Records
☐ History and Physical Exam
☐ Medication List
☐ Other Records or Test Results. Please Specify:_____

This request is being made:
☐ At the patient request ☐ At the request of the recipient

By **INITIALING** in the spaces below, I specifically authorize the disclosure of the following information that may have additional state and federal protections:

_____ Mental Health Information
_____ Drug/Alcohol Conditions
_____ HIV/AIDS Information
_____ Genetic Information

Release of the above information is limited to:

_____ Time period
_____ Treatment dates

3. I authorized the information designated above to be released from:

Name of Facility: _____
Street Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

4. I authorize the information designated above to be released to:

Applegate Medical Associates
689 E 19th Ave
Eugene, OR 97401
541-868-1876
541-868-0932

5. Expiration of Authorization of Release

This authorization is valid for 90 days from the date of this authorization or until ____/____/_____, unless revoked by the patient in writing at an earlier time. I understand that if I am requesting information from Applegate Medical Associates, I can revoke this authorization in writing and I will need to send a letter to the organization that gave out the information, and who is shown above. The exception is when the action has already occurred as instructed in this authorization. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

6. Disclosure and Authorization Signature

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or in order for payment for healthcare to be made. However, if the healthcare services are going to be provided solely for providing health information to someone else, then my signature on this authorization is necessary to make this disclosure. I will not receive these health services if I refuse to sign. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Applegate Medical Associates. I understand that if the organization that gets this information is not a healthcare provider by Federal Privacy Laws, the information listed above could be given out by them, and will not be protected by those regulations. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, genetic information or referral information.

_____
Signature of Patient or Authorized Representative Today's Date

_____
Printed Name of Patient or Authorized Representative Legal Representative's Relationship to Patient

APPLEGATE MEDICAL ASSOCIATES
689 E 19th Ave
Eugene, Oregon 97401
(541) 868-1876
John Allcott, M.D. Katelyn Kirchheimer, FNP-C Henry Elder, M.D

PAYMENT POLICY

We at Applegate Medical Associates strive to provide personal, responsive health care. In addition to providing the best in health care to our patients, we want to ensure that the financial aspects of your health care are dealt with in a straightforward and efficient manner, and that you are familiar with our billing and payment policy so that you are able to keep your health care costs manageable. Please read it, ask any question you may have, and sign in the space provided. A copy will be provided to you upon request.

INSURANCE

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of a claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

NON-COVERED SERVICES

Please he aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

NONPAYMENT

If your account is over 30 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS

Our policy requires that you give at least 24 hours' notice of cancellation. Please help us to serve you better by keeping your regular scheduled appointment. Three consecutive no show appointments will result in dismissal from our practice.

Our practice is committed to providing the best medical treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

_____
Print Patient Name

_____ _____
Signature of patient or responsible party Date

Applegate Medical Associates, LLP
689 E 19th Ave
Eugene, OR 97401
(541) 868-1876

John V. Allcott III, M.D. Katelyn Kirchheimer, FNP-C Henry Elder, M.D.

FINANCIAL AGREEMENT

Thank you for trusting Applegate Medical Associates to partner in your healthcare. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service; I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Patient Signature	Printed Name	Date
Parent/Guardian Signature	Printed Name	Date

Insurance:

Your insurance coverage is a contract between you and the insurance company, and it's your responsibility to know your insurance benefits.

As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare:

We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fee and notifies you of your financial responsibility for certain medical services.

Managed Care:

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies,

your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Patient Responsibility for Payment:

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due within 30 days of receipt.

Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all of the required information is provided. We will not bill or contact and non-custodial parent on behalf of the custodial parent.

Deposits:

If insurance co-payment and coverage cannot be verified, patients are required to pay a deposit in the amount of $75 on or before the first date of service. If payment results in a credit balance, it will be refunded within 30 days.

Payment Options:

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our Business Office at (541)868-1876 to make payment arrangements.

We offer a sliding scale program to our uninsured patients; please contact our office for an application to see if you qualify.

Accounts with a patient due balance outstanding over 90 days will be charged a rebilling fee based on the balance due. This fee will be waived if you abide by the terms of your payment agreement.

Non-Payment:

Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must then contact our collection agency to discuss payment arrangements. Referral to a collection agency, or naming Applegate Medical Associates in a bankruptcy filing, may result in dismissal from our practice.

If we refer your account for legal action, you will be charged a processing fee and any applicable legal fees. Referral to a collection agency will result in a $50 processing fee. NSF checks will result in a $25 processing fee.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact
Amy Tully at our office
(541) 868-1876
689 E 19th Ave, Eugene, OR 97401

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice, post a copy in our lobby and on our website. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require

information about you that we have.

- **For payment**. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law. Your information will never be sold to a third party and there will be no marketing of services to you.

- **Breach of Unsecured PHI**
  Unplanned release of "unsecured PHI" is always a breach and we have a duty to notify you if a breach occurs.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

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

- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

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

- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military

authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease (for instance, immunization records for schools)to prevent , injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **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.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by

your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Amy Tully in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

  We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to Amy Tully.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to Amy Tully. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your

request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to Amy Tully.

  If you choose to be treated for a medical condition and do not want your insurance company to be billed, you may pay for the visit at the time of service and those records will never be shared with a third party. You must make this request at each visit and pay at the time. This right is extended to patients covered by a government plan such as Medicare and Medicaid, as well as private third party payers.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Amy Tully. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to an Electronic Copy of PHI**
  You have a right to request and obtain an electronic form of your PHI. We have a 30-day window in which to comply with your request. The records will be supplied to you on a flash drive.

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

  To obtain such a copy, contact Amy Tully.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

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 Amy Tully, HIPAA Compliance Contact, (541) 935-2035. ***You will not be penalized for filing a complaint.***