THE FACE & BODY CENTER
PLASTIC & HAND SURGERY ASSOCIATES, PLLC

PATIENT DEMOGRAPIC INFORMATION

CHART #: _____

PATIENT NAME: _____ **GENDER:** ☐MALE ☐FEMALE

ADDRESS: _____ **CITY**_____**ST**_____ **ZIP**_____

Please check the box to indicate your preferred contact number:

☐ **HOME PHONE #:** ( ) _____ ☐ **WORK PHONE #:** ( ) _____

☐ **CELL PHONE #:** ( ) _____ **EMAIL ADDRESS:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

MARITAL STATUS: ☐Single ☐ Married ☐Separated ☐Divorced ☐Widowed **LANGUAGE:** ☐English ☐Spanish ☐Other: _____

ETHNICITY: ☐Not Hispanic/Latino ☐Hispanic/Latino **RACE:** ☐ American Indian ☐Asian ☐African American ☐White ☐Other: _____

PATIENT'S EMPLOYER: _____
List Employer Name, Address, Phone

RESP. PARTY INFORMATION

Please complete if patient is under 18 **OR** Insurance is under Parent/Guardian

RESP. PARTY NAME: _____ **GENDER:** ☐MALE ☐FEMALE

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: Self Spouse Child Other: _____

ADDRESS: _____ **CITY**_____**ST**_____ **ZIP**_____

HOME PHONE #: ( ) _____ **WORK PHONE #:** ( ) _____

ALT PHONE #: ( ) _____ **EMAIL ADDRESS:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

RESP. PARTY EMPLOYER: _____

INSURANCE INFORMATION

Please complete this section below accurately & bring your insurance cards/driver's license up with you for scanning.

PRIMARY INSURANCE COMPANY: _____**Copay $**_____

ADDRESS: _____

SUBSCRIBER'S NAME: _____**CONTRACT (ID#) NUMBER:** _____

SUBSCRIBER DOB: _____ **SUBSCRIBER SSN:** _____

GROUP NAME: _____ **GROUP NUMBER:**_____

PATIENT RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other: _____

SECONDARY INSURANCE COMPANY: _____**Copay $**_____

ADDRESS: _____

SUBSCRIBER'S NAME: _____**CONTRACT (ID#) NUMBER:** _____

SUBSCRIBER DOB: _____ **SUBSCRIBER SSN:** _____

GROUP NAME: _____**GROUP NUMBER:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other: _____

PATIENT NAME: _____ CHART # _____

REFERRING PHYSICIAN: _____ REASON FOR REFERRAL: _____

IS TODAY'S VISIT RELATED TO AN INURY? Y N **WORK RELATED?** Y N **AUTO RELATED?** Y N
If Yes:
DATE OF ACCIDENT / INJURY:_____ EMPLOYER CONTACT: _____

CASE WORKER NAME: _____ CLAIM #: _____

***WHAT PROMPTED YOU TO CALL FOR AN APPOINTMENT?* (Please check all that apply):**
☐ **PHYSICIAN REFERRAL** ☐ **HOSPITAL** ☐**WEBSITE** ☐ **INTERNET SEARCH** ☐ **BILLBOARD** ☐ **NEWSPAPER** ☐ **TV**
☐ **YELLOW PAGES** ☐ **MAGAZINE** ☐ **RADIO** ☐ **FAMILY MEMBER** ☐ **FRIEND** ☐**OTHER:**

***IF FAMILY/FRIEND REFERRED, MAY WE CONTACT THEM TO SAY "THANK YOU"? YES NO**
WHO MAY WE CONTACT (FAMILY/FRIEND NAME): _____

I have read and agree to the terms within the separately attached policies entitled:
FINANCIAL POLICY NOTICE, NOTICE OF PRIVACY PRACTICES, ASSIGNMENT OF BENEFITS

Authorization & Release of Information
According to office policy, test results or release of medical information will be provided to the patient only. If you would like your information to be made available to someone else, please specify below whom information may be released to other than yourself.

Authorized Name(s) & Relationship(s): _____

Authorized Name(s) & Relationship(s): _____

Communication Authorization
I hereby authorized and understand that in order for Plastic & Hand Surgery Associates, PLLC (PHSA) to service my account or to collect any amounts owed, PHSA may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which I understand could result in charges to me. I hereby authorize that PHSA may also contact me by sending text messages or e-mails, using any e-mail address I have provided for use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that PHSA may contact me as described above.

Third Party Laboratory
I understand that all lab testing and pathology services utilized while in the care of Plastic & Hand Surgery Associates (PHSA) will be performed by a third party laboratory. ***I understand that I will receive a separate bill for those services*** *rendered and I am responsible for payment of those services. PHSA has agreed to transfer my insurance information at the time of service so that rendered pathology services may be filed with my insurance company on my behalf.*

Patient Photographs
I consent to the photographing or televising of the appropriate portions of my body for medical, scientific, educational or marketing purposes, provided my identity is not revealed by the pictures taken at Plastic & Hand Surgery Associates (PHSA). This includes, but is not limited to, testing facilities, consulting physicians, outpatient facilities and website.

Notice of Privacy Practices
I have received the Plastic & Hand Surgery Associates, PLLC Notice of Privacy Practices explaining the uses and disclosures of my health information.

***PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____**

Assignment of Benefits Form

Included Facilities: Plastic Hand and Surgery Associates and The Plastic Surgical Center of MS

I, ***(responsible party)*** _____ with insurance benefits through ***(responsible party employer name)*** _____ (Medicare, Medicaid or Individual Plan) ***hereby authorize all entitled benefits under my governing Plan/Policy to be directly paid to the provider listed above for all services rendered.*** I understand that I am entitled to all benefits that my Health and Welfare Plan is legally obligated to provide. I understand that my Plan Sponsor and Insurance Company are both required to accept this HIPAA compliant agreement and provide all entitled benefits following all terms, conditions and requirements of the governing Plan for all services rendered, as well as comply with all applicable state and federal governing laws based on all protected rights. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; state and federal law in assuring all rights and entitled benefits are received for services rendered by the said provider. I understand this authorization also covers any other provider of service directly associated with services rendered and requested by the above provider, including but not limited to surgical related services, anesthesia, diagnostic testing, labs, pathology, radiology, implants, tissues, durable medical equipment or any other services as ordered by the provider above involving treatment.

I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws***. I also understand I may be responsible for any and all amounts not payable by my insurance company including deductibles, co-pay, coinsurance amounts as well as any portion paid and not applied to in network benefits for any out of network services, non-covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all applicable laws.***

I hereby irrevocably, designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my Health and Welfare plan/Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full as entitled under my governing Plan, along with all rights and remedies under applicable governing law for all medical care and services provided. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any and all entitled plan benefits and rights to Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific health and welfare plan or governing policy are administered accurately and not withheld for services rendered, including all protected rights under applicable law to receive a copy of all relevant documents or data, governing plan documents, remedies, disclosures, appeal, administrative reviews and litigation on my behalf. This is a direct assignment of my rights and benefits under the governing plan/policy. I understand this payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits are not paid pursuant to applicable federal and /or state laws. I also authorize Provider to apply any refund that may be due to me on an account with one of the Included Facilities to an amount due from me on another account with one of the Included Facilities.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above and rendering services following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including medical records to any business associate, insurance company, adjuster, Plan Sponsor, governmental agency or attorney involved in this case or responsible for making sure all protected rights and entitled benefits are provided pursuant to the governing Plan, state and federal laws. I authorize all applicable Providers listed providing medical services or appointed business associates to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all claims and appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information, appeals, remedies and protected disclosures from my Plan or insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider acting as my personal representative. I understand this assignment will remain in effect until revoked by me in writing.

I authorize all providers included in this agreement to provide medical care reasonable and at the standard of care as required by state law.
A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Responsible Party (if under age 18) ***Date***

PLASTIC & HAND SURGERY ASSOCIATES - MEDICAL HISTORY FORM

Name: _____ Marital Status: S D M W Age: _____ Occupation: _____

What is the reason for today's visit: _____ When did the problem start: _____

Which doctor referred you to this office: _____ Office Location: _____

Preferred Pharmacy: _____ Location: _____

☐ **I grant my consent to allow my prescription history to import electronically into my medical record from the Sure Scripts Pharmacy Network if it is available.**

PAST MEDICAL HISTORY

☐ Stroke ☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure ☐ Irregular Heartbeat

☐ Lung Disease ☐ Kidney Disease ☐ Thyroid Disease ☐ Gout ☐ Arthritis

☐ Rheumatoid Arthritis ☐ Lupus ☐ Stomach Ulcers ☐ Reflux ☐ Headaches

☐ Depression ☐ Seizures ☐ Staph Infection ☐ Blood Clots ☐ Bleeding Disorder

☐ HIV/AIDS ☐ Cancer: _____

☐ Surgery: _____

_____

FAMILY HISTORY

(Please specify relationship – parent, sibling, child)

☐ Heart Disease ☐ Lung Disease ☐ Diabetes

☐ High Blood Pressure ☐ Stroke

☐ Cancer – please specify type(s): _____

SOCIAL HISTORY

☐ Tobacco/Vaping Use- How long: _____ How many packs per day: _____ Date Quit: _____

☐ Alcohol- How many drinks per week: _____

CURRENT REVIEW

Have you had any of the following **recently**- ☐ Chest pain ☐ Shortness of breath ☐ Fever/Chills ☐ Nausea/Vomiting

☐ Headaches ☐ Fainting ☐ Rashes ☐ Swelling ☐ Vision changes ☐ Difficulty urinating ☐ Muscle aches or cramps

ALLERGIES

☐ Penicillin ☐ Sulfa ☐ Cephalosporin(s) ☐ Codeine ☐ Latex ☐ Other: _____

HAND PATIENTS

Are you right or left handed: ☐ Right ☐ Left Which hand(s) are you experiencing problems with: ☐ Right ☐ Left ☐ Both

Have you ever had a nerve conduction test: ☐ Yes ☐ No If yes, where: _____

VEIN PATIENTS

Concerns related to: ☐ Spider veins ☐ Leg Mass/Lumps ☐ Leg Swelling/Edema ☐ Leg Pain/Cramps ☐ Restless Leg Syndrome

BREAST REDUCTION PATIENTS

It is possible your insurance company may require a 2-year stable weight history:

Today's Weight? _____ Weight 2 years ago? _____

MEDICATIONS

(Please list all medications below – or attach list separately)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____

I hereby attest that this information is true, accurate and complete to the best of my knowledge:

Patient Signature: _____ Today's Date: _____

PLASTIC AND HAND SURGERY ASSOCIATES AND THE PLASTIC SURGICAL CENTER OF MISSISSIPPI
FINANCIAL POLICY NOTICE

Payment Guarantee: For services rendered by the "facilities" as listed above, you guarantee payment of your account at the time services are provided for any and all costs that will not or are not paid by an insurance carrier, government payer (including Medicaid), and other third party payer (together, referred to as "PAYER"), including in the event that if at a later date after initial approval your Payer denies your claim. You further understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that if your dependent is provided services you will be responsible for payment under these same policies, terms, and conditions. The "Responsible Party" listed on the Patient Data Sheet will be sent the Statement and shall be responsible for paying it. If the Responsible Party is not you and that person does not pay the bill, YOU are responsible for satisfying the Statement.

Assignment of Benefits: To the extent there is third party coverage for payment of services, you agree that all medical and related benefits PAID by PAYER will be irrevocably assigned to the "facilities" as listed above on your behalf.

Billing Information: It is essential that you provide us with complete and accurate information so that we may properly submit billing information to your insurance company (i.e. home address, phone numbers). We will make every effort to submit claims to your insurance company and promptly provide you with our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, you may be dismissed in accordance with these policies, terms, and conditions and referred to a collection agency. To avoid this, please ensure that all of your information is accurate, current, and up-to-date. Please be sure to bring your government-issued photo identification and your insurance cards to every visit so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

Medicare Agreement: If you have Medicare coverage, you acknowledge that payment of benefits will be made to you or on your behalf for any services furnished to you by the "facilities" as listed above (or the party who accepts assignment), including your physician services. You authorize any holder of medical or other information about you to release to Medicare and its agents, any information needed to determine these benefits or any benefits for related services.

Payment terms: We require payment at the time of your office visit. If you fail to make payment at the time of service we may charge an extra processing fee in recognition of the expenses of preparing and sending out a Statement. Depending on your insurance policy benefits, this payment could be for a co-payment, coinsurance, deductible, or for the entire services rendered at that visit.

Insurance Billing: As your healthcare provider we will file your claims with your insurance company as a courtesy after services are provided, however, if you notify us not to file it with your Payer we will honor your request. It is your responsibility to understand what services are covered under your medical insurance policy. If you have any questions whether a service will be covered we urge you to contact your insurance company before the service is provided. The codes that are listed for the services that are provided to you are based on the guidelines of the American Medical Association. There are several factors involved when making the decision for the type of services to be billed. Among those deciding factors are whether you are a new patient, the reason for the visit, the amount of time the service takes, and the complexity of the medical problem.

Insurance companies make their payment decisions about specific medical services by looking at what your insurance policy provides. **Example: If the reason for your visit is a sports physical and your insurance company does not cover that service we cannot go back and change the reason for your visit. It is your responsibility to find this out ahead of time.**

Routine services such as office visits, laboratory services, mammograms, screenings, and annual physicals may be covered under your insurance policies. If they are not covered you will be fully responsible for them. We suggest that you contact your insurance company to find out what benefits you have under your policy before services are rendered. The customer service number is usually found on your insurance card.
Your insurance company may require a pre-certification, prior authorization, or referral for some services, such as: radiology, surgery, or specialist visits. Receiving prior authorization does not guarantee that your insurance company will pay for it. Patients have the responsibility to ensure that prior authorization is obtained prior to services rendered. You should normally receive a response from your insurance company within 30 days. This is in the form of an "Explanation of Benefits" (or "EOB"). If you do not receive it, we would appreciate you contacting your insurance company to check the status of your claim in order to expedite payment. Please call our Billing Department if you encounter any difficulty with your insurance company and we will try to assist you. You are responsible for payment until the account is paid in full by your insurance company. Once we have received an EOB from your insurance company indicating the amount you will be responsible for, a Statement for the balance will be sent to you and payment is expected by the due date contained on our statements.

Interest and Attorney's Fees: In the event that amounts due on account of services provided to you are not satisfied when due, the "facilities" as listed above shall be entitled to charge interest at the rate of 1% per month, minimum $2, and you shall be responsible for all costs and expenses incurred in efforts to collect any unpaid amounts due from you, including any interest charges due, court costs, and all reasonable attorney's fees. Further, in the event that a check is returned for insufficient funds, all charges incurred by the "facilities" as listed above shall be your responsibility.

Collections: I agree to pay up to 100% of the unpaid balance for collection fees, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that I am responsible for reasonable collection costs and in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court. I hereby waive all rights to claim exemption of personal property and wages from execution, garnishment, or attachment pursuant to a lawful judgment otherwise granted to me under the laws and constitutions of the state of Mississippi and the United States.

Note to third parties and/or divorced parents of dependents: The Statement for your dependent will be sent to you and you are expected to pay it promptly. Even if you do not believe you are the "responsible party" we expect you to make payment, and then you can take action on your own to recoup from the party you believe responsible.

Workers Compensation Injury: If you believe you are being seen for an injury/illness as a result of your job, we must have written authorization from your employer to confirm this, and directions from your employer regarding who we should bill for this service. If we do not have this information at the time services are provided, we will bill you and/or your insurance company.

PLASTIC AND HAND SURGERY ASSOCIATES AND THE PLASTIC SURGICAL CENTER OF MISSISSIPPI
FINANCIAL POLICY NOTICE

Self-Pay Services: Are services that are not covered by an insurance policy or third party payer. Self-Pay patients are required to pay prior to **services being rendered.** No claim forms are prepared or billing statement is to be mailed. The Self- Pay fee schedule includes a discount for full payment. Payment plans may be approved on a case by case basis with administrative approval and are subject to additional fees.

Payment is YOUR responsibility: Our relationship is with you, to provide quality healthcare to you and/or you're dependent. Consequently, **all charges incurred are your responsibility**. The obligation to ensure payment in a timely manner lies with you. Unfortunately, we cannot always depend on your insurance company to make timely payment on your behalf. We are not responsible for delays, misplaced claims, or the need for additional information from you by your insurance company.

Payment Options: If you are unable to meet your financial obligation, payment arrangements can be made. Financing options may be available. Contact our Billing Department to discuss payment options, **before your account becomes overdue**. In cases of financial hardship you might be considered under our hardship policy and you may ask us about it.

Patient Consent for Use of Credit Cards, Debit Card and Financing: *Disclosure of Protected Health Information*
It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow COMPANY to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

- ✓ **I will not challenge such credit, debit, or financing card payments once the services are provided.**
- ✓ **I agree that this non credit card challenge agreement is irrevocable.**
- ✓ **By signing this notification, I acknowledge that I understand the policy of The COMPANY regarding my financial obligations.**

Making Payments: Patients may pay by cash, money order, check or personal credit card, which can include credit cards to pay from your "flexible spending account" and/or "health savings account," if you have these. One, or all, of these cards may be used to pay your bill, and may be kept on file by us to facilitate billing. Patients agree if they have a credit balance after paying for a service, the "facilities" as listed above can apply it to any outstanding balances on their account(s).

1. All cosmetic cases are to be paid in full prior to scheduling.
    - Any cosmetic cancellation within 5 days prior to surgery will result in a $1000 cancellation fee or the lesser quoted fee. This fee may be waived with a one-time option by the patient if rescheduling for another date within the next 6 months. Upon rescheduling, the cost/fee is locked in and there will be no refund. Should cancellation happen again at any time, all fees/monies will be forfeited.
2. All insurance cases are to have their deposit paid in full, 10 days prior to surgery.
    - For any insurance cancellation within 5 days prior to surgery, the cancellation fee is $500. The fee may only be waived by rescheduling for another date within the next 6 months and refund will not be an option. For patients with no deposit required, this will result in billing of $500. Upon rescheduling, the cost/fee is locked in and there will be no refund. Should cancellation happen again at any time point, any fees/ monies paid will be forfeited.

Fees Assessed: You may be charged fees for the following: ***(1) Returned Checks (2) Completion of Forms*** (e.g. Disability or Family Medical Leave) ***(3) Copying of Medical Records (4) Failure to Cancel Appointment ("No Show")*** - if you do not advise us of your inability to keep your appointment prior to 24 hours before your appointment.

Termination of Services: If you do not respond to 3 notices to the address we have on file, you agree that PHSA may terminate your relationship with all of its offices. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual provider/location.

Authorization to Release of Medical Information: You authorize the release of information by the "facilities" as listed above to third party payers, health care institutions, physicians and other providers involved in your medical care. You agree that as necessary for your care, PHSA may share information with family members and friends as minimally necessary to make decisions about your care. You agree that the "facilities" as listed above may provide your medical records to third-party payers, insurance companies, review agencies, employers, welfare departments, and to third-party data service providers, including Health Information Exchanges, like the Indiana Health Information Exchange (IHIE). This may include records about infectious diseases and drug and alcohol abuse treatment.

Accidents and Motor Vehicle Injuries: In all cases you bear the responsibility for these costs and must pay those promptly at any time that location decides to bill you directly.

Continuing Agreement: These policies apply to current and future health care services provided by the "facilities" as listed above. The "facilities" as listed above may change these terms without notice.

Notice of Privacy Practices

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about your privacy practices by providing your with this Notice. We must follow the privacy practices as described below. This Notice will take effect April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. For example: We may disclose medical information about you to doctors, nurses or other healthcare professionals involved in your care. For example, you doctor will need to know if you are allergic to any medicines. The doctor may share this information with pharmacists and others caring for you.

We may also disclose information to other professionals providing your health care. For example, we may need to tell a specialist about your medical conditions if we refer you to a specialist so you may receive proper care.

Disclosure: We may disclose and/share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. If you have health insurance, we request payment from your health plan for the services we provide. For example, we may need to give your health plan information about your visit, your diagnosis, procedures, and supplies used so that we can be compensated for the treatment provider. However, we will not be able to disclose your health information to a third party payer without your authorization except required by law. We may also tell your health plan about your recommended treatment to get their prior approval, if that is required under your insurance plan. For example, if you need surgery, we will call your health plan to make sure the surgery is covered and will be paid for by the health plan.

Emergencies: We may use and disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. For example, we may use your health information to review the quality of services you receive or to provide training to our staff.

Required by Law: We may use or disclose your health information when we are required by law to do so. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and/or Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voice mail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, a record of these disclosures is not kept; therefore it would not be available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Confidential Communication: You have the right to request to receive confidential communications by alternative means or at alternate locations. We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to our Privacy Officer.

QUESTIONS AND COMPLAINTS:

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

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