Advanced Women's Healthcare, SC

Account #: _____

Registration Form

Employee Initials: _____

PATIENT INFORMATION: (Please use full legal name/how it appears with your insurance company)

Last Name: _____ First Name: _____ Middle Initial: _____

Maiden Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: ( ) _____ Home Phone: ( ) _____ Work: ( ) _____

Which number is your preferred contact number? (circle one) Cell Home Work

Date of Birth: _____ **Sex**: Female Male **Marital Status**: Single Married Divorced Widowed

Social Security #: XXX-XX-_____ Email address: _____

Employer: _____ Primary Care Physician: _____

GUARANTOR INFORMATION: (List person or insured name that is responsible for bill)

Relationship of Guarantor to the patient: Self Spouse Parent Other

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: ( ) _____ Social Security #: XXX-XX-_____ Date of Birth: _____

Employer: _____ **Sex**: Female Male

INSURANCE INFORMATION: (Please allow the receptionist to take a copy of your Insurance card or cards)

PRIMARY INSURANCE: _____ Insureds name: _____

Insured's Date of Birth: _____ Relationship to patient: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claims Address (on back of your card):_____

Phone Number: ( ) _____

SECONDARY INSURANCE: _____ Insureds name: _____

Insured's Date of Birth: _____ Relationship to patient: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claims Address (on back of your card):_____

Phone Number: ( ) _____ ****AWH, SC does not accept Medicaid/IDPA plans as secondary payor****

EMERGENCY CONTACT:

Name: _____

Relationship to patient: _____ Phone Number: ( ) _____

Preferred Pharmacy: _____ Phone Number: ( ) _____

Address: _____ City: _____State: _____ Zip Code: _____

Electronic Prescriptions: Our electronic medical record program assesses your prescription medication history in order for us to safely prescribe your medication and allows our office to send electronic scripts to your pharmacy of choice. By signing, you authorize this service:

Signature: _____ Date: _____

1. What category best describes your race, please circle one:

African American American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander

Caucasian Decline to Answer I do not identify with any of those listed

2. Do you consider yourself to be Hispanic or Latino, please circle one:

Yes, Hispanic or Latino No, not Hispanic or Latino Decline to Answer

3. What is your preferred language? _____

Patient Portal:

I authorize Advanced Women's Healthcare, SC to send test results and patient portal information via email.

Signature of Patient: _____ Date: _____

Email Address for patient portal access: _____

PLEASE INITIAL NEXT TO EACH STATEMENT

_____ **Consent for Treatment**

I hereby authorize employees and agents of Advanced Women's Healthcare, SC to provide medical care to the patient indicated on this form. I understand that this includes evaluations and treatment as well as lab tests, education, other diagnostic procedures and in some cases, medical and/or surgical procedures.

_____ **Patient's Right to Privacy**

I acknowledge that I have had the opportunity to review the Advanced Women's Healthcare, SC Notice of Privacy Practices. These privacy practices are always available in the front office and I understand that should I desire a copy of the HIPPA privacy practice in the future, I can request a copy from the office staff.

_____ **Appointment Cancellation/No Show Policy**

Effective January 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office providing at least a 24 hour notice will be considered a no show and assessed a $30 fee. Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office providing at least a 24 hour notice a second time, will be assessed a $50 fee. If a third no show/late cancellation or reschedule occurs without at least a 24 hour notice, the patient may be discharged from Advanced Women's Healthcare, SC. A no show fee is charged directly to the patient, not the insurance company and is expected to be paid prior to the next appointment at Advanced Women's Healthcare, SC.

Any new patient who fails to arrive for an initial visit will not be rescheduled. If unable to make appointment date and time, please give 24 hour notice to reschedule.

We understand that at times there may be extenuating circumstances that do not allow for a greater than a 24 hour notice. You may contact Advanced Women's Healthcare, SC Monday through Friday 7:30 am to 4:00 pm. On the weekend or after hours, it is possible to send our office a non-urgent message through our website at awhcare.com. If you should experience an extenuating circumstance, please contact our Office Manager, who may be able to waive the No Show fee.

_____ **Financial Policy**

Advanced Women's Healthcare, SC accepts most insurance plans and will submit claims to those insurance plans on your behalf. It is your responsibility to provide our office with accurate insurance information so that claims can be submitted timely. It is also your responsibility to determine what services your insurance company will cover. You are obligated to pay for all services provided to you whether they are covered by your insurance company or not. This includes deductible, copayments, co-insurance amounts as well as plan limitations. Plan limitations could include such things as pre-authorization, pre-certification, referral from a PCP and medical necessity limitations set by your insurance company. Should you experience a lapse in coverages, you will able responsible for those charges. If you need to be referred to a specific lab, it is your responsibility to make your healthcare provider aware of that. We will bill a secondary insurance unless the secondary insurance is Medicaid or any of the IDPA plans. As of June 25, 2013 Advanced Women's Healthcare, SC no longer accepts any of the Medicaid/IDPA plans as a secondary payor and I understand that this means any deductible and/or copayment/co-insurance amounts left by my primary commercial payor are my responsibility to pay out of pocket. In addition, our office is not contracted with all Medicaid plans and it is your responsibility to ensure that you remain on a Medicaid plan that our office participates in for your services to be covered. Any services provided by outside laboratories (bloodwork, paps, or biopsies) will be billed to you directly by that company.

_____**Financial Policy Continued**

You will receive a statement showing the charges that have incurred on your account and the amount due once we have heard back from your insurance company, if you provided insurance at your visit. All patient balances are expected to be paid in full within 30 days of the date of your statement. Payment of unpaid balances must be paid prior to any new services being rendered. Appointments will not be scheduled until balances are paid in full.

OB patients will be provided with an OB Cost Estimate, in most cases within the first trimester. This will outline the anticipated costs for the pregnancy. Services not include in the OB Package are expected to be paid within the 30 days of your statement being printed. The global charges will be submitted to your health insurance following delivery. Once hearing back from your health insurance, we will bill you and expect payment in full within 30 days of the statement date. Payment plans **will not** be an option following delivery.

Should your account become delinquent and sent to an outside collection agency, you will be responsible for the costs incurred in the collection of this balance, which includes collection agency fees of 30%, court costs, and attorney fees. Any account sent to collections will no longer be able to receive future services in our office. Any check returned for insufficient funds will incur a $25 charge on the patient account.

I authorize Advanced Women's Healthcare, SC to release to my insurance company and its agents any information necessary to determine the benefits payable under their coverage. I authorize my insurance company and its carries to disclose any information requested regarding claims for medical benefits. A copy of this authorization may be used in place of the original.

I request the payment of authorized medical benefits made on my behalf to Advanced Women's Healthcare, SC for services provided to me by its providers and staff.

_____ **HIPPA Consent**

I hereby authorize Advanced Women's Healthcare, SC to discuss my protected health information with the following individuals:

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

By signing below, I acknowledge that I have read and understood the Patient Registration, Consent for Treatment, Patient's Right to Privacy, Appointment Cancellation, No Show Policy, and Financial Agreement and that I agree to abide by the office policies of Advanced Women's Healthcare, SC.

Signature of Patient (or guarantor if patient is a minor): _____

Printed Name of above signature (and patient name if a minor): _____

Date of signed agreement: _____

Advanced Women's Healthcare

Dele Ogunleye, MD
Lisa Emm, MD
Angela Baja Catarinicchia, MD

Brittany King, APN, WHNP
Jackie Deffenbaugh, APN, WHNP

2111 E Oakland Ave, Suite B
Bloomington, IL 61701
Phone 309.808.3068
Fax 309.808.3072

www.awhcare.com

Obstetrics | Gynecology | Urogynecology | Minimally Invasive Surgery | Infertility

Authorization for Release of Confidential Health Information

1. Individual Information:

Printed Name of Patient_____ Date of Birth_____

Address _____

Phone Number _____

2. Information may be disclosed by:

Name of Organization or person releasing information _____

Address _____

Phone Number _____ Fax Number _____

3. Information may be disclosed to:

Name of Organization or person receiving information: Advanced Women's Healthcare

Address: 2111 E Oakland Ave Suite B Bloomington, IL 61701

Phone Number: 309-808-3068 Fax Number: 309-808-3072

4. What information do you want disclosed? (Choose ONE option, copy fees may apply)

[ ] Information from the most recent 2 years of visits

[ ] All information from date ____ /____ /_____ to date ____ /____ / ____

[ ] Information regarding specific treatment, condition, or other (specify):

_____

5. Why are you asking for this health information to be released? (Choose ONE option)

Attorney Insurance Doctor Medical Leave Personal Other (specify) _____

6. Authorization: The medical information to be released as specified above may include any of the following information as it pertains to the request: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. By my initials and signature, I give my specific authorization for this information to be released. **_____ (initial)**

[ ] Mental Health [ ] Developmental Disabilities [ ] Alcohol/Substance Abuse [ ] HIV/AIDS [ ] Other_____

7. Expiration: This authorization expires in 90 days from the date signed or on the date or event indicated here:

_____

8. Signature: _____ Date: _____ /_____ /_____

9. Signature of Witness: _____ Date: _____ /_____ /_____

Advanced Women's Healthcare Patient Health History

Name: _____ DOB: _____

Reason For Today's Visit:

_____

_____

_____

Drug Allergies:

_____

_____

_____

Current Medications- Prescribed and OTC: Please include dose and how medication is taken (daily, twice per day….etc.).

_____

_____

_____

_____

Preferred Pharmacy: _____

Are you menopausal? YES NO If yes, at what age? _____

Have you had a hysterectomy? YES NO If yes, were your ovaries removed? YES NO

Are you sexually active? YES NO

Do you use any form of birth control? YES NO If yes, what kind? _____

Have you ever had a colonoscopy? YES NO If yes, date? _____

Facility performed at? _____

Have you ever had a bone density test? YES NO If yes, date? _____

Facility performed at? _____

Menstrual History (If you are NOT menopausal)

Are your cycles regular? YES NO

Date of last menstrual period? _____

Pap Smear History

Date of last pap smear: _____ NORMAL ABNORMAL

History of abnormal pap smears? YES NO

Breast:

Ever had a Mammogram? YES NO Date of last Mammogram? _____

History of Abnormal Mammogram? YES NO Facility performed at? _____

Advanced Women's Healthcare Patient Health History

Pregnancy History: Including all miscarriages and/or abortions

#	Date	Sex Of Baby	Weight Of Baby	Weeks' Gestation	Type Of Delivery	Complications: During Pregnancy or During Labor
1						
2						
3						
4						
5						
6						

Personal History Of:

YES	NO		YES	NO	
___	___	Anemia	___	___	High Blood Pressure
___	___	Anxiety	___	___	High Cholesterol
___	___	Asthma	___	___	Hyperthyroidism
___	___	Blood Clots (PE, DVT…etc.)	___	___	Hypothyroidism
___	___	Depression	___	___	Osteoporosis
___	___	Diabetes (circle one) Type 1 or Type 2	___	___	Panic Attacks
___	___	Polycystic Ovarian Syndrome	___	___	Recurrent UTI's
___	___	Endometriosis	___	___	Sleep Apnea
___	___	Fibroids	___	___	Stroke
___	___	Glaucoma	___	___	Urinary Incontinence

Autoimmune Disorder? (If yes, please specify)_____

Heart problems? (If yes, please specify) _____

_____

Cancer? (If yes, please list what type and when) _____

_____

Sexually Transmitted Diseases? (Ever in your life): Gonorrhea Chlamydia Herpes HPV Syphilis HIV None

Please specify any other medical condition you may have that is not listed in the above section:

_____

_____

_____

Advanced Women's Healthcare Patient Health History

Past Surgical History:

_____

_____

_____

Past Hospitalizations:

_____

_____

_____

Family History: List all health issues; cancer, diabetes, heart problems, etc.… Please specify

Father: Alive or Deceased _____

Mother: Alive or Deceased_____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Siblings: _____

Other: _____

Social History:

- Marital Status (circle one) - Single Married Divorced Widowed
- Smoking Status (circle one)- Never a smoker Current smoker Former smoker: Quit date _____

  If you are a current smoker, how many cigarettes per day?

  ___ 5 or less ___ 6-10 ___ 11-20 ___ 21-30 ___ 31 or more
- Illicit Drug use? YES NO If yes, what type? _____
- Alcohol Consumption - Have you had a drink in the past 12 months? YES NO

  If yes, how often?
  - ___ Monthly or less
  - ___ 2-4 times per month
  - ___ 2-3 times per week
  - ___ 4 or more times per week

  If yes, how many drinks in a typical day?
  - ___ 1 or 2
  - ___ 3 or 4
  - ___ 5 to 6
  - ___ 7 to 8
  - ___ 10 or more
- In a normal day, what is your caffeine intake? _____
- In a normal week, how much exercise do you get? _____

Please complete the back side of this form

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)

0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly everyday

	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

NOTICE OF PRIVACY PRACTICES

Advanced Women's Healthcare, S.C.

Amy Peasley, Privacy Officer

Effective Date: September 1, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a computer in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

22. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

23. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

24. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

25. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

26. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted

or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

27. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

B. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.