Alexander Poisik MD 301 NW 84 Ave, #206, Plantation, FL 33324 PHONE (754) 238-1964 - FAX (754) 238-1803

PATIENT INFORMATION

PATIENT'S NAME			DATE	RIGHT HAND LEFT HAND # OF CHILDREN
SS#	DOB	AGE	SEX M F	MARITAL STATUS S M W D SEP
HOME ADDRESS CELL #	CITY, STATE, ZIP CODE			HOME PHONE #
Employment status: __employed _unemployed __retired _student	EMPLOYER NAME AND PHONE #		OCCUPATION	
EMERGENCY CONTACT (NOT LIVING WITH YOU)		PHONE #		RELATIONSHIP
SPOUSE'S NAME		SPOUSE'S CONTACT PHONE # (NOT SAME AS HOME #)		
PATIENT'S EMAIL ADDRESS: Y N				Authorize E-mail?
PATIENT'S RACE:	ETHNICITY:	PREFERRED LANGUAGE:		HEIGHT:

REFERRING PHYSICIAN INFORMATION

PHYSICIAN'S NAME/SPECIALTY	PHONE #

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
CLAIM ADDRESS		CLAIM ADDRESS	
INSURANCE PHONE #		INSURANCE PHONE #	
POLICY #	GROUP #	POLICY #	GROUP #
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER'S SS#	SUBSCRIBER'S DOB	SUBSCRIBER'S SS	SUBSCRIBER'S DOB
EMPLOYER'S NAME	EMPLOYER'S PHONE #	EMPLOYER'S NAME	EMPLOYER'S PHONE #

ACCIDENT INFORMATION

TYPE OF ACCIDENT? (Please Circle)	HOME AUTO WORK SLIP&FALL OTHER		
AUTO ACCIDENT YES NO	DATE OF ACCIDENT	WORKMAN'S COMP ACCIDENT YES NO	DATE OF ACCIDENT
AUTO INSURANCE COMPANY NAME		WORKMAN'S COMPENSATION COMPANY NAME	
ADJUSTER NAME & PHONE #		ADJUSTER NAME & PHONE #	
POLICY HOLDER'S NAME/PHONE #/RELATIONSHIP		EMPLOYER'S NAME AT TIME OF ACCIDENT	
POLICY # (ID CARD)	CLAIM # (ISSUED FOR CASE)	CLAIM #	

ATTORNEY INFORMATION (IF YOUR COMPLAINT IS PART OF A LEGAL MATTER)

NAME	PHONE #

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, MEDICAID, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO Alexander Poisik MD THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT. RETURNED CHECKS AND BALANCE OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION, ATTORNEY, COURT COSTS AND INTEREST CHARGES OF 1.5% PER MONTH. A $20 FEE WILL BE INCURRED FOR NO SHOWS IF APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE. I CERTIFY THAT I HAVE READ AND UNDERSTAND FULLY THE PROVIDERS BILLING POLICY AND AGREE TO MAKE PAYMENT IN FULL AND/OR SATISFACTORY ARRANGEMENTS WHEN ASKED TO DO SO AS SPECIFIED ABOVE.

PATIENT SIGNATURE_____DATE_____

IF MINOR, PARENT/GUARDIAN SIGNATURE_____

NAME: _____

DOB: _____

Reason for today's visit:

_____

_____

Please rate your pain on an average day due to this condition by circling a number below:

1 2 3 4 5 6 7 8 9 10

Please list any CURRENT medical problems:

_____

_____

_____

Please list all past surgeries and hospitalizations:

Procedure/Hospitalization	Date (Approximate)	Complications (if any)

Do you currently smoke? ☐ **YES** ☐ **NO** **Years smoked**_____ **Packs/Day**_____

Did you smoke previously? ☐ **YES** ☐ **NO** **Years smoked**_____ **Packs/Day**_____

Other Tobacco Products? ☐ **YES** ☐ **NO** **Description and Amount:** _____

Consume Alcohol? ☐ **YES** ☐ **NO**

Signature_____ Date_____

NAME: _____

DOB: _____

Please list any Allergies to any medications or substances you may have:

☐ **No drug allergies | No other allergies**

Allergy	Reaction

Please list ALL current medications including any over the counter medications, herbs, supplements, vitamins including the dose amount and how many times per day:

_____

_____

_____

_____

_____

Please list any major illnesses/medical conditions of family members:

Relative	Condition	Currently Living?	Age if deceased

Signature_____ Date_____

Preferred Contact Method

Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell — YES _____ NO _____ (initial yes or no)
- Leave a detailed message with individual answering the phone — YES _____ NO _____ (initial yes or no)

Sharing of Medical Information

I give the physician and office staff of Alexander Poisik MD permission to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Authorization for e-PRESCRIBE

e- Prescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. E-Prescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Alexander Poisik MD to enroll me in the ePrescribe Program.

Patient signature _____ Date _____

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of Alexander Poisik MD to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO

I authorize the physician and/or staff of Alexander Poisik MD to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above-named insurance company to pay directly to Alexander Poisik MD the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Patient Authorization for

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and Alexander Poisik MD to photograph me for medically related documentation purposes.

Patient signature _____ Date _____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Alexander Poisik MD of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Alexander Poisik MD is the patient's responsibilities.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. I acknowledge that I have received a copy of the Alexander Poisik MD Notice of Privacy Practices.

_____ _____ _____

Printed name Signature Date signed

Financial Policy and Signature on File

I understand that I am financially responsible for all services rendered and for the following reasons:

If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company *(This applies to present and future visits).*

Payment is required for all services at the time they are rendered including deductible co-payments and any outstanding balances.

An appointment which is not cancelled 24 hours in advance and is missed will be considered a "no show" and will be subject to a $25.00 fee

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. RETURNED CHECKS AND BALANCE OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION, ATTORNEY, COURT COSTS AND INTEREST CHARGES OF 1.5% PER MONTH

.Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Signature_____ Date_____

Patient or Responsible Party

At Alexander Poisik MD, we have the ability to send notifications regarding appointment reminders. using the Electronic Health Record services. These include Email, phone, and text messages (message and data rates may apply).

Please choose which contact methods you prefer (you may select more than one):

Email: ☐ **Phone:** ☐ **Text Message:** ☐

Patient Name *(Print)*_____

Signature_____ Date_____

Patient Portal Access

Alexander Poisik MD has the option of accessing your information in a safe, secure way through the web-based Patient Portal. You can access your health information including any educational documents that were discussed during your visit with our provider(s).

You have the choice to opt-in for access to your Patient Portal by providing your e-mail address and signing below. If you choose to access the Patient Portal, a confirmation will be sent to the provided e-mail address with instructions how to sign up / log in. You can request access at any time in the future.

☐ Yes, I wish to sign up for access to my patient portal.

Email Address: _____

☐ No, I DO NOT wish to have access to the patient portal.

Patient Name *(Print)*_____

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

Alexander Poisik MD

301 NW 84 Ave, #206, Plantation, FL 33324 PHONE (754) 238-1964 - FAX (754) 238-1803

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

Effective Date: July 1, 2020
This Notice was revised on: _____.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Alexander Poisik MD
Mailing Address: 301 NW 84 Ave, #206, Plantation, FL 33324-1807
Telephone: (754) 238-1964
Fax: (754) 238-1803

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or

coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

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

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. *(Optional)* If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

[Placeholder- Special Protections for HIV information, Alcohol and Substance Abuse information, Mental Health Information and Genetic Information.]

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may

prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form

that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Foreign Language Version *(Optional)*

If you have difficulty reading or understanding English, you may request a copy of this Notice in [Insert Language].