PATIENT INFORMATION DEMOGRAPHICS

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Sex: M F • Married: Y N • Partner: Y N

City: _____ State: _____ Zip: _____ Marital/Partners Name: _____

Occupation: _____ _____

Employer: _____ Email: _____

Employers Address and Phone#: _____ Social Security #: _____

_____ Driver's License #: _____ State: _____

Pharmacy Name and Address: _____ Mobile Phone: _____

_____ Home Phone If Different: _____

Pharmacy Phone: _____ Work Phone: _____

RESPONSIBLE PARTY INFORMATION (If different)

Name: _____ Relationship To Patient: _____

Address: _____ Mobile Phone: _____

City: _____ State: _____ Zip: _____ Home Phone If Different: _____

Email: _____ Work Phone: _____

HEALTH INSURANCE (Please give your insurance cards to the receptionist)

Insurance Co: _____ Policyholder's Name: _____

Address: _____ Relationship To Patient: _____

City: _____ State: _____ Zip: _____ Policyholder's DOB: _____

Effective Date: _____ Through: _____ Policyholder's SSN: _____

Phone: _____ Policyholder's Employer: _____

Plan Name: _____ Copay: $_____ Policy #: _____

Group #: _____

ADDITIONAL SECONDARY INSURANCE

Insurance Co: _____ Policyholder's Name: _____

Policyholder's Employer: _____ Relationship To Patient: _____

Policy #: _____ Policyholder's DOB: _____

Group #: _____

IN CASE OF AN EMERGENCY

Notify: _____ Relationship To Patient: _____

Home Phone: _____ Work Phone: _____

SIGNATURE

The undersigned verifies that the above information is true and correct:

Signature: _____ Date: _____

(If the patient is a minor – signature of parent or guardian)

Patient Communication Authorization

Date: _____

Patient's Date of Birth: _____

Patient's Name: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

Mobile Phone Number _____

- Can we text your mobile phone about appointments,
  e.g. appointment reminders, changes made to your appointment time, etc.? Yes ❑ No ❑
- Can we call this number and leave a message concerning your health? Yes ❑ No ❑

Email Address _____

- Can we email you about appointments,
  e.g. appointment reminders, changes made to your appointment time, etc.? Yes ❑ No ❑
- Can we email you with information concerning your health? Yes ❑ No ❑

Home Phone Number _____

- Can we call this number and leave a message concerning your health? Yes ❑ No ❑

Work Phone Number _____

- Can we call this number and leave a message concerning your health? Yes ❑ No ❑

❑ I give permission to the individual(s) listed below, to receive protected health information:
❑ You may also call these individuals on my behalf, at the phone number(s) listed below:

_____

_____

- This authorization can be revoked or modified by notifying us IN WRITING at any time.

_____ _____
Patient's Signature Date

Todays Date: _____

PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____ Sex _____ S. M. LTP. W. D.

Address _____ Tel. No. _____

Insurance Co. _____ ☐HMO ☐PPO Copay $ _____ Copay $ _____ Primary care Physician _____ Occupation _____

Mail Claim To _____ Policy No. _____

Instructions: Put ☑ In Those Boxes Applicable To You And In The "Yes" Or "No" Space. If Lines Are Provided Write In Your Answer.

Family History

	Father	Mother	Brother 1	Brother 2	Brother 3	Brother 4	Sister 1	Sister 2	Sister 3	Sister 4	Spouse/ Partner	Children 1	Children 2	Children 3	Children 4	Children 5	Children 6
Age (if Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (At Death)																	
Cause Of Death																	

Personal History

Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes
☐Scarlet Fever			Jaundice			☐Broken Bones ☐Cracked Bones		
Diphtheria			Epilepsy			Recurrent Dislocations		
Smallpox			Migraine Headaches			☐Concussion ☐Head Injury		
Pneumonia			Tuberculosis			Ever Been Knocked Unconscious		
Pleurisy			Diabetes			☐Food ☐Chemical ☐Drug Poisoning		
☐Rheumatic Fever ☐Heart Disease			Cancer			Explain		
☐Arthritis ☐Rheumatism			Colonoscopy / Sigmoidoscopy			Latex Sensitivity		
☐Bone Disease ☐Joint Disease			☐High ☐Low Blood Pressure			Chronic Fatigue Syndrome		
☐Neuritis ☐Neuralgia			Nervous Breakdown			Any Other Disease		
☐Bursitis ☐Sciatica ☐Lumbago			☐Hay Fever ☐Asthma			Explain		
☐Polio ☐Meningitis			☐Hives ☐Eczema					
☐Gonorrhea ☐Syphilis ☐HIV			Frequent ☐Colds ☐Sore Throat			Weight: Now One Yr. Ago		
Anemia			Frequent ☐Infections ☐Boils			Maximum When		

Allergies

Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes
☐Penicillin ☐Sulfa Drugs			Any Other Drugs			Any Foods		
☐Aspirin ☐Codeine ☐Morphine			Explain			Explain		
☐Mycins ☐Other Antibiotics			Iodine Or Radiologic Dye					
☐Tetanus ☐Antitoxin ☐Serums			Adhesive Tape			☐Nail Polish ☐Other Cosmetics		

Surgery

Have You Had Removed . . .	No	Yes	Have You Had Removed . . .	No	Yes	Have You . . .	No	Yes
Tonsils			☐Ovary ☐Ovaries			Had Hernia Repaired		
Appendix			Hemorrhoids			Had Any Other Operations		
Gall Bladder			Ever Have A Transfusion			Been Hospitalized For Any Illness		
Uterus			☐Blood ☐Plasma			Explain		

X-Rays

Ever Have X-rays Of . . .	No	Yes	Date	Disease Present
Chest				
☐Stomach ☐Colon				
Gall Bladder				
Extremities				
Back				
Mammogram				
Sigmoidoscopy / Barium Enema				
Other				

Print Name: _____ Todays Date: _____

Review Of Systems

Do You Now Have Or Have You Ever Had . . .	No	Yes	Do You Now Have Or Have You Ever Had . . .	No	Yes
☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight			Kidney ☐ Disease ☐ Stones		
☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing			Bladder Disease		
Any Trouble With ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat			Blood In Urine		
Fainting Spells			☐ Protein ☐ Sugar ☐ Pus ☐ Other In Urine		
Convulsions			Difficulty In Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches: ☐ Frequent ☐ Severe			Prostate Trouble		
Enlarged Glands			☐ Stomach Trouble ☐ Ulcer		
Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged			Indigestion		
Enlarged Goiter			☐ Gas ☐ Belching		
Skin Disease			Appendicitis		
Cough: ☐ Frequent ☐ Chronic			☐ Liver Disease ☐ Gall Bladder Disease		
☐ Chest Pain ☐ Angina Pectoris			☐ Colitis ☐ Other Bowel Disease		
Spitting Up Blood			☐ Hemorrhoids ☐ Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness Of Breath ☐ Exertion ☐ At Night			☐ Constipation ☐ Diarrhea		
☐ Palpitation ☐ Fluttering Heart			☐ Parasites ☐ Worms		
Swelling Of ☐ Hands ☐ Feet ☐ Ankles			☐ Any Change In Appetite ☐ Eating Habits		
Varicose Veins			☐ Any Change In Bowel Action ☐ Stools		
Extreme ☐ Tiredness ☐ Weakness			Explain		

Immunization - EKG

Have You Had . . .	No	Yes	Have You Had . . .	No	Yes
Smallpox Vaccination (Within Last 7 Years)			Polio Shots (Within Last 2 Years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram When		
Hepatitis Vaccination					

Social History

Do You . . .	No	Yes	Do You Use . . .	Never	Occ.	Freq.	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours Sleep (Per Night)			Sleeping Pills				
Have Regular Bowel Movements			Aspirins				
Sex - Entirely Satisfactory			Cortisone				
Like Your Work (Hours Per Day) ☐ Indoors ☐ Outdoors			Alcoholic Beverages				
Watch Television (Hours Per Day)			Tobacco: Cigarettes (Pks Per Day)				
Read (Hours Per Day)			☐ Cigars ☐ Pipe ☐ Chewing Tobacco				
Have A Vacation (Weeks Per Year)			☐ Snuff				
Have You Ever Been Treated For Alcoholism			☐ Other Drugs				
Have You Ever Been Treated For Drug Abuse			Appetite Depressants				
Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week?			Thyroid Medication: ☐ No ☐ Yes, In Past ☐ None Now ☐ Now On Gr. Daily Have You Ever Taken: ☐ Insulin ☐ Tablets For Diabetes ☐ Hormone Shots ☐ Tablets ☐ No				

Women Only

Menstrual History . . .	No	Yes		No	Yes
Age At Onset			Are You Regular: ☐ Heavy ☐ Medium ☐ Light		
Usual Duration Of Period Days			Do You Have ☐ Tension ☐ Depression Before Period		
Cycle (Start To Start) Days			Do You Have ☐ Cramps ☐ Pain With Period		
Date Of Last Period			Do You Have Hot Flashes		
Pregnancies . . .	No	Yes	Cervical & Vaginal Cancer Risk Assessment:	No	Yes
Children Born Alive (How Many)			**1) Did you have sexual intercourse before the age of 16?**		
Cesarean Sections (How Many)			**2) Have you had more than five partners in your lifetime?**		
Have you had a Pap test in the past 7 years?			**3) Have you ever had a sexually transmitted disease?**		

Emotions

Are You Often . . .	No	Yes	Are You Often . . .	No	Yes
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

Clinic Policies
Acknowledgement & Consent

Patient name:_____Date of birth: _____

I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to the physician(s) or medical clinic for any services furnished to me: (a) Granting an irrevocable assignment of your patient's right and or my right to reimbursement for covered services rendered ("Covered Services"); and (b) Granting you a power of attorney to submit, negotiate, and appeal that claim in the patient's name.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I understand that all inactive medical records are destroyed after six years; and that if I want them I need to claim them before six years. I also authorize the release of any information required to process insurance claims including any information relating to drug or alcohol abuse, and AIDS/HIV.

Financial Arrangements:
Our clinic participates with few insurance plans. Our list of plans may change periodically. You are responsible for making sure that we are currently participating with your carrier. You are responsible to notify us which diagnostic testing laboratory your insurance is contracted with, otherwise you may be liable for non-contracted laboratory services.

We offer the following methods of payment: Cash, Personal Check, Visa, and MasterCard. If you do not have insurance, we require full payment at the time of service. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance prior to your appointment.

I agree to pay for any letter; note; forms required for a return to work, disability, insurance, DMV, or for legal purposes; that I request to be completed and signed at $50/page and $25 each additional page. I agree to pay a $6.00 rebilling fee for each month that I carry a balance beyond 60 days. I agree to pay $75 for a missed appointment if cancelled with less than 24 hours' notice.

Acknowledgment of Receipt of Privacy Notice:
I have been presented with a copy of the clinics "Notice of Privacy Policies", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I place no additional restriction(s) concerning my personal medical information:_____.
This authorization regarding how my information may be used and disclosed, in order to maintain my privacy, may be revoked in writing by me at any time.

Signed: _____ Date: _____
(If patient is a minor - signature of parent/guardian)

COUNSELING & PSYCH SERVICES
Telebehavioral Health Services Informed Consent Form

In order to ensure ethical and quality care, please read this Telebehavioral Health Services Informed Consent form carefully before your online or telephone appointment. You will have an opportunity to ask your provider any questions about this appointment format and give your verbal consent prior to starting your appointment. Please read to the bottom
and follow the instructions for providing electronic written consent to your provider.

1. I understand that my mental health care provider has invited me to engage in a telebehavioral health visit via Zoom or other secure video conferencing platform that is HIPAA compliant. Telebehavioral health includes secure videoconferencing, telephone conversations, and education using interactive audio, video, or data communications.

2. I understand there are potential risks to this format, including:
(1) unexpected interruptions
(2) unauthorized access
(3) technical difficulties
(4) some individuals may find remote visits less satisfying
(5) remote visits are insufficient for high-risk individuals and emergency situations

3. I understand that there are potential benefits to this format, and these include:
(1) convenience
(2) flexibility
(3) health-conscious
(4) the same benefits of treatment on my original consent for treatment: reduction of symptoms, improved quality of life,
emotional well-being, and improved academic performance. There is no guaranteed outcome.

4. I understand that I have the following alternatives to a telebehavioral health visit:
(1) a list of self-help resources
(2) list of community providers
(3) an in-person visit, if feasible

5. Eligibility.
I understand that I am only eligible for counseling visits if I am physically in the state where the doctor is licensed, due to state licensing requirements. If I am out of the state, I can receive a brief consultation visit (to check in, obtain guidance about resources, etc.). I also understand that psychiatric services may be provided across state lines for medication management but some prescriptions for controlled substances cannot be filled across state lines.

6. Confidentiality.
Confidentiality still applies for telebehavioral health services. Neither myself nor my provider will be recording any of my visits. It is important that we avoid the use of public/free Wifi.

7. Consent for minors.
If I am under the age of 18, your physician will need the written permission of my parent or legal guardian (and their contact information) for me to participate in this format.

8. Required Information.
Prior to my first visit, I will provide to my provider at least one emergency contact and their phone number in the event my provider is concerned about my imminent safety and is not able to reach me. If my provider is unable to reach my emergency contact and my provider continues to be concerned about my imminent safety, local police may be contacted to request a welfare check. At the beginning of each video conference visit I may need to confirm my identity by showing my ID Card or other official photo identification. If contact is by telephone, I will confirm my name and identification numbers if applicable.

9. Emergency services.
I understand and accept that teletherapy does not provide emergency services. If I am experiencing an imminent emergency, I understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I may also call the National Suicide Prevention Lifeline at 1- 800-273-TALK (8255) for free 24 hour hotline support.

10. Accountability.
If I need to cancel or change my appointment I will do so by 4pm the day before to avoid a late fee. Timeliness is important. I understand that I am recommended to log on to the website 5-10 minutes prior to a scheduled appointment to manage any technical difficulties. I understand that if I am not present in the Zoom or online meeting by 5 minutes after the scheduled start of the visit, my provider will be contacting me by telephone.

10. Substance Use.
Consumption of alcoholic beverages or use of illicit drugs during my sessions is not permitted. My session will be terminated if I am under the influence of alcohol or drugs.

11. Attire.
I will dress as if the session were in-person.

12. Venue.
I will select a location for my sessions that is quiet, private and sufficiently well lit to allow my provider to easily see my face during the visit.

13. Connectivity.
I am aware that I must have access to a webcam and microphone via a computer, tablet or smart phone. I am aware that sometimes technology fails to perform to an appropriate standard. If provider is unable to reach me by video within the first few minutes of a scheduled session or loses connectivity during a visit, he or she will call me on the designated back up phone number that is on file. I understand that my provider or I can discontinue the telebehavioral health visit if they determine that the videoconferencing connections are not adequate for my situation.

16. Other participants.
I understand that I will need to notify my provider in advance if I plan to include the presence of another individual in the visit. I and my provider will have the right to request the following:
(1) omit specific details in discussion of topics that are personally sensitive to me
(2) ask the individual joining the visit to leave if they are disruptive or not conducive to the effectiveness of the visit
(3) terminate the visit at any time

17. Billing.
I understand that billing will occur for any billable services provided.

Patient Name:

DOB:

MR #:

PSYCHIATRY INFORMED CONSENT TO TREATMENT

Index to Consent – Treatment/Procedures – Behavioral Health

Date: _____

I understand that I may have a behavioral health condition that may require treatment. I consent to the proposed evaluation and/or treatment provided at our – Department of Psychiatry. I understand that the services available to me may include but are not limited to:

- evaluation,
- diagnosis,
- treatment planning,
- individual and group counseling,
- medicine,
- family counseling,
- education, and
- discharge planning and referral.

I understand how the services are provided. When possible, my behavioral health provider will discuss other treatment options with me. This could include referrals to other providers, alcohol and/or drug treatment, information on community resources, or other options.

Risks and Benefits

I understand that there are potential risks and benefits of participating in a program for behavioral health treatment.

Benefits may include but are not limited to:

- improved quality of life,
- fewer psychological symptoms,
- reduced health risks and medical problems,
- improved family, social and employment relationships.

Risks may include but are not limited to:

- Medication related side-effects,
- anxiety related to making life changes,
- effects on personal relationships, and
- others' negative perceptions about mental health treatment.

There are some likely consequences of not receiving behavioral health treatment. These may include but are not limited to:

- psychological distress,
- decreased life satisfaction,
- impaired employment, and
- a negative impact on relationships.

Privacy Rights

Your right to privacy is important to us. State and federal laws and our high ethical standards require that we keep patients' health information confidential. Laws also limit the ways we can use and share that information. Information about your behavioral health condition(s) and/or treatment may be shared with other UW Health or outside health care providers involved in your care as necessary for your continuing treatment. Your physical and mental health affect each other; sharing information with all of your health care providers allows them to best meet your health needs.

UW Health may also share information as necessary for purposes of payment and health care operations, and as otherwise allowed by state and federal law. More details about how you may use and share your health information is contained in the Notice of Privacy Practices. A copy of this was provided to you.

I understand my rights, including my right to withdraw my consent in writing at any time. I have been offered a copy of those rights. I understand the clinic's grievance procedure and have been offered a copy.

I have read and understand all of the information given to me. I have been given enough time to ask questions or get more information and to get answers to my questions. The risks and benefits of the treatment and other treatment options have been made clear to me. I have been told what may happen if I do not have treatment. The information provided to me is specific, accurate and complete. I consent to evaluation and treatment at UW Health – Department of Psychiatry. This consent expires 15 months from the date of my signature below, upon my discharge or when I give written notice that my consent is terminated (if earlier than 15 months from the date of my signature).

I may request and receive a copy of this consent.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative _____ Date: _____ _____ _____Time: _____

If signed by person other than the patient, print name and state relationship and authority to do to.

Print Name: _____ Relationship: _____

Patient is: Minor Incompetent/Incapacitated

Legal Authority: Legal Guardian Parent of Minor

Health Care Agent Other: _____

*Physician Signature: _____ *Print Physician Name: Heather Saltos MD

Date: _____ _____ _____Time: _____

_____ _____

Interpreter or Reader Signature (if applicable) Witness Signature**

_____ _____

Print Interpreter or Reader Name Print Witness Name

_____ _____ _____ _____ _____ _____ _____ _____

Date Time Date Time

* Provider can be Physician or Advanced Practice Provider

** Only required if patient signature not obtained by physician or when telephone consent obtained.

Notice of Privacy Practices

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

Effective Date September 23, 2013

A. PURPOSE OF THIS NOTICE.

This medical office is committed to preserving the privacy of your health information. In fact, we are required by law to do so for any health information created or received by us. We are required to provide this Notice of Privacy Practices ("Notice") to you. The Notice tells you how we can and cannot use and disclose the health information that you have given to us or that we have learned about you when you were a patient in our system. It also tells you about your rights and our legal duties concerning your health information.

We are required to abide by this Notice and any future changes to this Notice or law at all of our locations, including medical schools, medical residency programs, hospitals, skilled nursing facilities; numerous primary care and specialty clinics; multiple research institutes and centers; and several community service and outreach programs. This Notice applies to the practices of:

- All of our employees, volunteers, students, residents and service providers, including clinicians, who have access to health information.
- Any health care professional authorized to enter information into your health record.
- Any clinicians who might otherwise have access to your health information created or kept by us, as a result of, for example, their on-call coverage for our clinicians.

For the rest of this Notice," we" and "us" will refer to all services, service areas, and workers on our staff. When we use the words "your health information," we mean any information that you have given us about you and your health, as well as information that we have received while we have taken care of you (including health information provided to us by those outside of our facilities).

We will have a copy of the current Notice with an effective date in clinical locations and on our website.

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND FOR OUR HEALTH CARE OPERATIONS.

1. Treatment, Payment and Health Care Operations.

The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. For each of those categories, we explain what we mean and give one or more examples. Not every use or disclosure will be noted and there may be incidental disclosures that are a byproduct of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

a. For Treatment. We may use your health information to provide you with medical or dental treatment or services. We may disclose your health information to staff physicians, staff dentists, post-graduate fellows, midwives or nurse practitioners, and other personnel involved in your health care. We may also disclose your health information to students and resident physicians who, as a part of their educational programs (and while supervised by physicians or dentists), are involved in your care. Treatment includes (a) activities performed by nurses, office staff, hospital staff, technicians and other types of health care professionals providing care to you or coordinating or managing your care with third parties, (b) consultations with and between our providers and other health care providers, and (c) activities of other physicians or other medical providers covering our practice by telephone or serving as the on-call provider.

   For example, a physician or dentist treating you for an infection may need to know if you have other health problems that could complicate your treatment. That provider may use your medical history to decide what treatment is best for you. They may also tell another provider about your condition so that he or she can decide the best treatment for you.

b. For Payment. We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else for health care services you receive from us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

   For example, we may need to give your health plan information about surgery you received at any facility so that your health plan will pay us or reimburse you for the surgery.

c. For Health Care Operations. We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at our facility. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about patients to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective. Or we may give health information to doctors, nurses, technicians, or health profession students for review, analysis and other teaching and learning purposes.

2. Fundraising Activities. As a part of our healthcare operations, we may use and disclose a limited amount of your health information internally, or to other charitable foundations to allow them to contact you to raise money. The health information released for these fundraising purposes can include your name, address, other contact information, gender, age, date of birth, dates on which you received service, health insurance status, the outcome of your treatment at our facility and your treating physician's name and department at our facility. Any fundraising communications you receive from us or our Foundations will include information on how you can elect not to receive any further fundraising communications from us or them.

3. Uses and Disclosures You Can Limit

a. Hospital Directory. Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital. Specifically, your name, location in the hospital and your general condition (e.g., good, fair, serious, critical) may be released to people who ask for you by name. In addition, your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name.

b. Family and Friends. Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the exam room during treatment.

   Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care. For example, we may tell someone who comes with you to the emergency room that you suffered a heart attack and provide updates on your condition. We may also make similar professional judgments about your best interests that allow another person to pick up such things as filled prescriptions, medical supplies and X-rays.

C. OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION.

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. Required By Law: As required by federal, state, or local law.
2. Public Health Activities: For public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, school immunizations under certain circumstances or problems with products.
3. Victims of Abuse, Neglect or Domestic Violence: To a government authority authorized by law to receive reports of abuse, neglect or domestic violence when we reasonably believe you are the victim of abuse, neglect or domestic violence and other criteria are met.
4. Health Oversight Activities: To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
5. Lawsuits and Disputes: In response to a subpoena, discovery request or a court or administrative order, if certain criteria are met.
6. Law Enforcement: To a law enforcement official for law enforcement purposes as required by law; in response to a court order, subpoena, warrant, summons or similar process; for identification and location purposes if requested; to respond to a request for information on an actual or suspected crime victim; to report a crime in an emergency; to report a crime on our premises; or to report a death if the death is suspected to be the result of criminal conduct.
7. Coroners, Medical Examiners and Funeral Directors: To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.
8. Organ and Tissue Donation: To organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.
9. Research: For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process.
10. Serious Threat to Health or Safety; Disaster Relief: To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to your health and safety or that of the public or another person, or (ii) to notify your family members or persons responsible for you in a disaster relief effort.
11. Military: To appropriate domestic or foreign military authority to assure proper execution of a military mission, if required criteria are met.
12. National Security; Intelligence Activities; Protective Service: To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
13. Inmates: To a correctional institution (if you are an inmate) or a law enforcement official (if you are in that person's custody) as necessary (a) to provide you with health care; (b) to protect your or others' health and safety; or (c) for the safety and security of the correctional institution.
14. Workers' Compensation: As necessary to comply with laws relating to workers' compensation or similar work-related injury program.

D. WHEN WRITTEN AUTHORIZATION IS REQUIRED.

Other than for those purposes identified above in Sections B and C, we will not use or disclose your health information for any purpose unless you give us your specific written authorization to do so. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes that encourage you to purchase a product or service, and for sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, deliver a written revocation to us. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information which we list below. In each of these cases, if you want to exercise your rights, you must do so in writing. You can get information about how to exercise your rights and about any costs that we may charge for materials by contacting us directly.

1. Right to Inspect and Copy. With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in our electronic health record, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
2. Right to Amend. You have the right to amend your health information maintained by us, or used by us to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.
3. Right to an Accounting of Disclosures. You have the right to request a list and description of certain disclosures by us of your health information.
4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service for which we have been paid out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a surgery you had, a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in 4(c) above, we are not required to agree to your request. Any time we agree to such a restriction, it must be in writing and signed by our Privacy Officer or his or her designee.
5. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain place. We will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.
6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, whether or not you may have previously agreed to receive the Notice electronically.
7. Right to be Notified of a Breach. You have the right to be notified if there is a breach – a compromise to the security or privacy of your health information – due to your health information being unsecured. We are required to notify you within 60 days of discovery of a breach.

F. REVISIONS TO THIS NOTICE

We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. We will post the revised Notice at our clinical locations and on its website and provide you a copy of the revised notice upon your request.

G. QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact us directly. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with us, begin the process by contacting our practice manager by calling the office. You will not be penalized for filing a complaint.

This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.