Oregon Psychiatric Partners, L.L.P.
&
Franc Strgar, MD, P.C.

PATIENT DEMOGRAPHICS **TODAYS DATE** _____

PATIENT NAME: _____ PREFERRED NAME: _____
FIRST M.I. LAST

DATE OF BIRTH: _____ AGE: _____ SEX: MALE___ FEMALE___ SSN# _____ SEX: MALE___ FEMALE___

MARITAL STATUS: ___SINGLE ___MARRIED ___SEPARATED ___DIVORCED ___WIDOWED

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

MAILING ADDRESS (If Different From Above): _____ CITY: _____ STATE: _____ ZIPCODE: _____

PREFERRED PHONE #_____ CELL HOME WORK // **OK TO LEAVE MESSAGE**: YES NO EMAIL ADDRESS: _____

APPOINTMENT REMINDER METHOD (Please Choose All That Apply): EMAIL _____ TEXT _____ TELEPHONE/VOICEMAIL _____

I do not wish to receive appointment reminder notifications _____

EMERGENCY CONTACT: _____ **PHONE**: _____ **PRIMARY CARE PROVIDER**: _____ **PHONE:** _____

PREFERRED PHARMACY (Name and Location): _____ **PHONE**: _____

PRIMARY INSURANCE: ARE YOU ELIGIBILE FOR MEDICARE? YES NO

PLAN NAME: _____ I.D. #: _____ GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDERS DATE OF BIRTH: _____

RELATIONSHIP TO POLICY HOLDER: Self_____ Parent _____ Spouse / Partner _____

SECONDARY INSURANCE:

PLAN NAME:_____ I.D. #:_____ GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

RELATIONSHIP TO POLICY HOLDER: Self_____ Parent _____ Spouse / Partner _____

PERSON RESPONSIBLE FOR BILL (ONLY COMPLETE IF DIFFERENT FROM PATIENT):

RESPONSIBLE PARTY NAME: _____ DATE OF BIRTH: _____ PHONE #:: _____
First Last

ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

RELATIONSHIP TO PATIENT: Parent _____ Spouse / Partner _____ Other (please specity):_____

OPTIONAL INFORMATION

PREFERRED LANGUAGE: ___ ENGLISH ___ OTHER: (please list): _____ RACE: _____ ETHNICITY: _____ NON HISPANIC _____

HOW DID YOU HEAR ABOUT US? WEBSITE FRIEND/FAMILY PROVIDER REFERRAL (Provider Name): _____ OTHER: _____

By signing below I agree to receive appointment reminders in the method I have selected above. I understand I can revoke my selection at any time by submitting a written or verbal request to the office.

Patient / Legal Guardian Signature X _____ Date: _____

Oregon Psychiatric Partners, L.L.P.

3203 Willamette Street, Eugene OR 97405
1831 NW Kings Blvd, Corvallis OR 97330
Phone: 541-726-9912 Fax: 541-744-4443

CONSENT FOR TREATMENT AND BILLING

PATIENT NAME: _____ DATE OF BIRTH: _____

CONSENT FOR TREATMENT:
In mutual agreement with the provider, the undersigned hereby consents to all necessary treatments and/or diagnostic procedures within the scope of the practice of psychiatry/behavioral health services. I understand that my treatment and records are confidential as outlined by State and Federal Law. This consent also includes treatment (telephone or in person services) provided by any on-call provider.

X_____ _____
Patient Signature/ Legal Guardian Signature Date

CONSENT FOR TELEMEDICINE SERVICES:
I understand telemedicine services may be available to me. Upon program acceptance and in mutual agreement with the provider, the undersigned hereby consents to all necessary treatments and/or diagnostic procedures within the scope of the practice of psychiatry/behavioral health services via videoconferencing. I consent to using live video conferencing services provided by Oregon Psychiatric Partners Telemedicine Program. I understand that these services may involve the communication of my health information, both orally and visually, to the provider. Specifically, I understand that videoconferencing services include, but are not limited to, consultation, treatment, and transfer of health data using interactive audio, video, or data communications. I also understand that no data or health information will be recorded, stored, or archived from use of these live videoconferencing services.

I further understand the following with respect to use of Oregon Psychiatric Partners telemedicine services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my health information may also apply to these services as such, I understand that the information disclosed by me during the videoconference session is generally confidential. However there are both mandatory and permissive exceptions to confidentiality.
3. There are risks and consequences from use of these services, including, but not limited to, the possibility, despite reasonable efforts on the part of Oregon Psychiatric Partners, that: the transmission of my health information could be disrupted or distorted by technical failures; and/or transmission of my health information could be intercepted or accessed by unauthorized persons.
4. I have a right to access my health information and copies of health records in accordance with HIPAA privacy rules and applicable state law.
5. I understand videoconference sessions are billable in the same manner as my face to face sessions and that I am financially responsible for all fees regardless of insurance coverage. I further understand that all fees are to be paid at the time of service and I will call the office to make my payment prior to each video session.

I have read and understand the information provided above. I have discussed it with representatives from Oregon Psychiatric Partners, and all of my questions have been answered to my satisfaction.

X_____ _____
Patient Signature/ Legal Guardian Signature Date

NOTICE TO OUR PATIENTS WITH INSURANCE:
Your insurance is NOT a guarantee of payment. All fees and expenses incurred by the patient in this office are solely the responsibility of the patient (or parent, if patient is a minor). As a service to you, we will complete and submit your insurance claim. Regardless of any insurance claims, full payment is due in 60 days.

ASSIGNMENT OF INSURANCE BENEFITS:
I authorize the above providers to furnish my third party payer all relevant information which may be requested regarding my claim, including activities involved in determining eligibility, diagnosis, review of health care services for medical necessity, precertification and preauthorization, thus releasing any of the above providers from any liability for furnishing such information. I assign all payments to which I am entitled for expenses related to the services performed, but not to exceed my indebtedness to the above providers. It is understood that any money received from the insurance company over and above my indebtedness will be refunded when my bill is paid in full. My financial responsibility may be different from that stated on my insurance card because of psychiatric specialty fees and may not be known until after the insurance has paid. I understand that I may be billed for lengthy telephone consultations and reports, which may not be reimbursable by insurance. I understand that I am financially responsible for all fees regardless of insurance coverage and that it is customary to pay for services when rendered unless other arrangements have been made in advance.

By signing below I acknowledge I have read and understand the office policy statement and understand my financial responsibility.

X_____ _____
Signature of Person Financially Responsible for Payment Date

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Name: _____ **DOB:** _____ **Date:** _____

Are you Allergic to any Medications? ☐YES ☐NO *If yes, please list medications below

Medication	Reaction

What Prescription Medications you are **Currently** taking: attach a current med list

Name of Medication	Amount/Dose	Name of Prescribing Doctor

Psychiatric Medications Tried & Failed	Amount/Dose

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FAMILY/FRIEND RELEASE OF INFORMATION FORM

I, _____ _____
(print patient name) (patient date of birth)

hereby authorize the providers and staff of Oregon Psychiatric Partners LLP and Franc Strgar MD PC to inform and/or involve the following family members and friends in my care and treatment planning. I understand that the providers and staff may verbally share information with the family and/or friend(s) listed below about my care plan, appointments, or account status. I understand that this release will also allow persons I have listed below to share information with the providers and staff regarding my condition.

Family and friends:

1. _____ _____ _____ _____
Relation Address/Street Phone/Home
_____ _____
City/State/Zip Phone/Work

2. _____ _____ _____ _____
Relation Address/Street Phone/Home
_____ _____
City/State/Zip Phone/Work

3. _____ _____ _____ _____
Relation Address/Street Phone/Home
_____ _____
City/State/Zip Phone/Work

4. _____ _____ _____ _____
Relation Address/Street Phone/Home
_____ _____
City/State/Zip Phone/Work

This authorization will remain in effect for the duration of my treatment or until cancelled in writing by the patient.

I understand I can cancel this release at any time, but the cancellation will not affect any information that was already released before the cancellation.

By signing below I understand that information specific to drug and alcohol treatment, psychiatric treatment, AIDS/HIV, and genetic test information can be released with this consent.

I understand information discussed may be re-disclosed by the receiving person and may no longer be covered under federal privacy laws.

I understand what this agreement means and I am satisfied with any explanations I may have requested and received.

_____ _____
Patient Signature Date

_____ _____
Person authorized to sign Relationship Date

Providers of:
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

Other Names Used: _____

For the purpose(s) of continuity of care, diagnosis, evaluation and treatment planning, I authorize my provider(s) at **OREGON PSYCHIATRIC PARTNERS, LLP, & FRANC STRGAR MD, PC** to release the following confidential information about me to the physician or organization listed below.

_____
(Name of Physician or Organization)

_____
(Address) (Telephone) (Fax)

By placing my initials here _____ I authorize the physician or organization listed above to release my medical record and information to my provider(s) at OREGON PSYCHIATRIC PARTNERS, LLP & FRANC STRGAR MD, PC.

I understand my record may include medical, mental health, and drug/alcohol diagnostic evaluations, treatment history, progress notes, summaries, medication history, laboratory test and reports, and hospital and immunization records.

I understand the following information can only be disclosed if I initial below. I further understand that federal and/or state laws prohibit the re-disclosure of mental health, drug and alcohol, and HIV/AIDS diagnoses and treatment information, and specific authorization is required for the release of such information.

_____ Mental Health records which may including drug/alcohol diagnoses and treatment or referral information
_____ HIV/AIDS related information and/or records
_____ Genetic Testing information and/or records

Please indicate purpose for this release:

☐ **Ongoing:** To Allow ongoing communication between my care providers.

☐ **Single Event**: This is a one-time request to transfer all my records from Oregon Psychiatric Partners to the entity listed above.

If you are requesting a specific record to be released, please specify the document below:

_____

By signing below:

I authorize the release of the medical records noted above and I understand the person or organization receiving these records could re-disclose the records and they may not be covered under federal privacy laws.

I understand this release will remain in effect until:

☐ My care is terminated by my provider or myself.

☐ The designated time period of _____ days has lapsed.

☐ The single event has been fulfilled, which I understand may take 30 days from the date of the request.

I understand that information about my care is confidential and protected by state and federal law and I may cancel this authorization at any time. To cancel the authorization, I must provide a written request to cancel. The request to cancel this consent will not affect information that was released prior to the date of my cancellation request.

I agree I have read the entire release and I understand this authorization is voluntary and I may refuse to sign the authorization. I understand if I do not sign this authorization it will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____ _____
Date Signature of Patient or Guardian Type of Guardianship

OPP Clinic Intake for Dan Bentley

Name: _____ **DOB:** _____ • _____ • _____

Main Concerns and/or goals for this visit: _____

_____

_____

_____

Psychiatric Symptoms Place a ✓ next to any problems below that you are currently experiencing:

___ Anxiety	___ Sadness/Crying Episodes	___ Isolation	___ Nightmares
___ Flashbacks	___ Panic Attacks	___ Racing Thoughts	___ Impulsivity
___ Suicidal thoughts	___ Suicidal Plans/Recent Attempts	___ Anger	___ Homicidal Thoughts
___ Cravings	___ ↑ Substances (alcohol, drugs etc)	___ Paranoia	___ Hallucinations
___ Not enough sleep	___ Sleeping too much	___ Other: _____	

Past Psychiatric History

1. Please list any Psychiatric diagnoses you've been given in the past, and how old you were:
   (ex. ADHD – 15, Depression – 20's, etc.) _____
   _____
2. Ever hospitalized for psychiatric reasons? ☐ No ☐ Yes, ___ time(s), most recent _____ (year)
   If yes: why hospitalized? _____
3. Have you ever attempted suicide? ☐ No ☐ Yes, ____ time(s), most recent _____ (year)
   If yes: how, why? _____
4. Have you ever hurt yourself on purpose (cutting, burning, etc) ☐ Never ☐ Yes
   If yes: how? _____ What age(s) or ☐ still going on - how often _____
5. If applicable, who last prescribed psych medications for you: _____
6. Have you ever had therapy? ☐ No ☐ Yes, but not helpful | ☐ Yes, and it was/is helpful
   If you are in therapy now: how long, and who with? _____

Past Psychiatric Medications Please list any psychiatric medicines you tried in the past, like for depression, anxiety, sleep, mood, addiction, or psychosis. Add " – H" if it was helpful, or "-N" for not helpful. If you can remember highest dose and how long you took it, and when, that's great. _____

_____

_____

_____

Past Medical History ☐ N/A, healthy ☐ High Blood Pressure ☐ Diabetes ☐ Chronic Pain ☐ Asthma
(list any other diagnoses, major surgeries, & family history of early death, unusual conditions, etc.)

_____

_____

_____ OVER ➤

OPP Clinic – Pre-visit Assessment for D. Bentley, PA-C

Name: Date: / / DOB / /

This form and all questions in it are optional. If you sign this, it will be securely shredded later.

Instructions: Use circles "O" or , ✓marks to indicate your answers.

Over the last 2 weeks, how often have you been bothered by any of the following?		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things?	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	2	3
4.	☐ Feeling tired or having little energy	0	1	2	3
5.	☐ Poor appetite or ☐ overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or let yourself or your family down.	0	1	2	3
7.	Trouble concentrating on things, such as reading, talking or watching television.	0	1	2	3
8.	☐ Moving or speaking so slowly that other people could have noticed? Or the opposite —☐ being so fidgety & restless that you've been moving around a lot more than usual.	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way…	0	1	2	3
	Questions #1-9 above help assess mood; those below assess anxiety. If you'd like, total just the scores for # 1-9 here ☞:				Sub-total: ____
10.	Feeling nervous, anxious or on edge	0	1	2	3
11.	Not being able to stop or control worrying	0	1	2	3
12.	Worrying too much about different things	0	1	2	3
13.	Trouble relaxing	0	1	2	3
14.	Being so restless that it is hard to sit still	0	1	2	3
15.	Becoming easily annoyed or irritable	0	1	2	3
16.	Afraid as if something awful might happen	0	1	2	3
	Questions 10-16 help assess anxiety; total the scores for # 10-16 here ☞:				Sub-total: ____

If applicable, how have these problems affected your work, home life, or getting along with others?
☐ Not at all difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Thanks! Please ✓ any of the following that apply & add comments below or on the back.
In the last month have you: ☐ Heard Voices or ☐ Seen things other people wouldn't
☐ Made any plans or attempts to hurt yourself ☐ Gotten into legal trouble ☐ Been hospitalized for any reason ☐ Started new medications prescribed elsewhere: _____
_____

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Billing Offices: (OPP) 541-248-2926 or (Dr. Strgar) 541-497-8009

PATIENT RIGHTS AND RESPONSIBILITIES

We consider you a partner in your health care. When you are well-informed, participate in treatment decisions and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. We encourage respect for the personal preferences and values of each individual.

While you are a patient of Oregon Psychiatric Partners and/or Dr. Franc Strgar, MD, P.C. your rights include the following:

- You have the right to considerate and respectful care.
- You have the right to be well informed about your illness, possible treatments and likely outcome and to discuss this information with your provider. You have the right to know the names and roles of the people treating you.
- You have the right to consent to or refuse a treatment as permitted by law. If you refuse a recommended treatment, you will receive other needed and available care.
- You have the right to privacy. Our group, your provider and others are caring for you will protect your privacy as much as possible.
- You have the right to expect a timely response to questions regarding medication and side effects.
- You have the right to expect that treatment records are kept confidential unless you have given permission to release information, or we are reporting as required or permitted by law. When we release records to others, such as insurers, it emphasizes that the records are confidential.
- You have the right to expect that we will give you necessary health services to the best of our ability. Treatment, referral or transfer may be recommended. If transfer is recommended or requested, you will be informed of risks, benefits and alternatives.
- You are responsible for providing information about your health, including past illnesses, hospital stays and use of medicine.
- You are responsible for asking questions when you do not understand information or instructions. If you believe you can't follow through with your treatment, you are responsible for telling your provider.
- You and those accompanying you are responsible for being considerate of the needs of other patients and staff.
- You are responsible for providing information for insurance and for working with us to arrange payment, when needed.
- Your health depends not just on the care you receive from your provider, but in the long term, on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal health.

BILLING RIGHTS AND RESPONSIBILITIES
IF YOU HAVE QUESTIONS REGARDING THIS NOTICE PLEASE CONTACT
THE OPP BILLING OFFICE AT (541) 988-3137 OR DR. STRGARS BILLING OFFICE AT (541) 485-1568

INSURANCE AND PREAUTHORIZATION

Insurance companies may require authorization for certain services. . Authorization does not guarantee payment. It is your responsibility to verify whether or not our providers are eligible for insurance reimbursement or if there are restrictions to your policy for specific providers or services. It is your responsibility to notify the office if your insurance requires preauthorization or if you have changes in your insurance plan or coverage. In many cases, you will be required to initiate the request for a referral to our office. It is also your responsibility to monitor the actual benefits you have used. If benefits terminate, authorized sessions have been used, or deductibles, co-pays or co-insurance are a requirement of your plan, you are personally responsible for the billed services.

NOTIFY US IN CASE OF ERRORS OR QUESTIONS ABOUT YOUR BILL

If you think your bill is wrong or if you need more information about a transaction on your bill, write to us at the address on your bill as soon as possible, but no later than 30 days after you receive the first statement on which the problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, identify the following information:

- Your name and account number (located on your statement)
- The name of your provider (located on your statement)
- Explain why you believe there is an error.

YOUR RIGHTS AND RESPONSIBILITIES AFTER WRITTEN NOTIFICATION

You must acknowledge your letter within 30 days unless we have corrected the error before then. Within 90 days, we must either correct the error or explain why we believe the bill is correct. You will continue to receive billing statements until the issue is resolved. If we find that we made a mistake on your bill, we will send you a statement of the corrected amount you owe and the day your payment is due.

PAYMENT OF ACCOUNT

Providers of Oregon Psychiatric Partners and Dr. Strgar MD, P.C. reserve the right to require prepayment of all services. Payment on the account is expected within 30 days following the statement closing date. All accounts not paid within 30 days may be considered past due unless payment arrangements are made. A $25 fee will be charged to the patient for any check returned to us for insufficient fund (NSF).

Your financial responsibility may be different from that stated on your insurance card because of psychiatric specialty fees which may not be known until after the insurance has been billed.

Completion of reports and forms are not a required responsibility of our providers. If Providers choose to complete reports and forms, or telephone calls become lengthy, these services are not reimbursable by insurance and you may be personally responsible for payment of these services.

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NOTICE: PATIENT PRIVACY

We understand that medical information about you and your health is personal. The providers and staff at Oregon Psychiatric Partners and Franc Strgar MD, P.C are committed to preserving the privacy of your personal health information. Additionally, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION:

- We may use and disclose health information about you for the purposes of treatment, payment and healthcare operations without obtaining your consent or authorization. Some examples may include; speaking with a physician if you are hospitalized, calling medications into a pharmacy, or submitting information to your insurance provider to obtain authorization or payment for services.
- We may disclose information about you when required to do so by federal, state or local laws. Examples of this purpose may include; Our receiving a court order or subpoena if you become involved in a lawsuit or dispute. Subject to all legal requirements, we may release health information about you in response to a subpoena.
- As our patient, you have important rights to inspect and receive a copy of your medical information that we maintain, you may request amending or correcting that information, obtain an accounting of the disclosures of your medical information, request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and register a complaint if you think your rights have been violated.
- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective Date at the top right hand side of this page indicates the date the most current NOTICE is in effect.
- You have the right to receive a copy of our most current notice in effect. If you have not yet reviewed a copy of our current notice, please ask the front desk and we will provide you with a copy.

OFFICE POLICY STATEMENT:

The office staff is available by telephone 9:00 am to 4:30 pm Monday through Friday. Please be advised that calls are transferred to the answering service daily from 11:30am-1:00pm. The office is closed on the first Friday of each month and on most national holidays. An operator is available at all times to assist you. Please listen carefully to the voicemail options and select the option that best fits your needs. . If you are unable to wait for a return call from the on-call provider, please go to your local Emergency Room.

Appointments and Emergencies

It is your responsibility to attend scheduled appointments. If you cannot keep your appointment, ***please call at least 24 hours in advance to cancel or re-schedule***. Frequent missed appointments or last minute cancellations may result in termination of your care in this office. If you are a patient of Dr. Leong, and you miss 2 appointments, or cancel up to 2 appointments in less than 24 hours, your services will be terminated at this practice. Additionally, if you are assigned to a new provider and you do not show for the initial visit your chart will be closed and you will not be eligible to reschedule with our providers.

If you have an urgent need during business hours or during evenings and weekends, you may be referred to the on-call provider if your regular provider is not available. In the event of an after hours emergency, the answering service can locate us and your call will be returned within 24 hours. If you are unable to wait for a return call from the on-call provider, please go to your local Emergency Room.

MEDICATION REFILLS

Please call your pharmacy at least 3 days before you need to pick up your medication, even if it says "No Refills". The pharmacy will notify us of your request. If your medication requires a written prescription please contact the office at least 3 business days before you need the medication. Mailing of a written prescription requires that you provide the office with self-addressed stamped envelopes. NO ROUTINE REFILLS WILL BE PROCESSED AFTER REGULAR BUSINESS HOURS.

PSYCHIATRIC FEES

You may be charged for other services such as phone calls, after-hour contacts, reports, records, and consultations with other professional services. Your insurance company will be billed for covered services; however, you will be expected to pay for any fees not covered by your insurance. You are expected to pay your "copay" "deductible" "coinsurance" or the amount we expect you will owe at the time of your appointment. Private pay accounts require payments in full at each appointment. Please feel free to discuss charges and fees with us.

REPORTS, DOCUMENTS AND RECORDS REQUESTS

If you are applying for disability, involved in a legal dispute, or require written reports for a third party insurance or any other entity, please be aware these items are not a requirement of our providers. Fees will be charged for the completion of all documents that are requested by you, your attorney, or third party entities. ***These fees are the responsibility of the patient and may be required to be paid prior to the completion of the document.*** Our providers will make every effort to complete the requested document within 14 days of receiving it. However, in some cases documents and medical records requests may take up to 30 days to complete.

TREATMENT PLAN

You have the right to participate in forming your treatment plan and to ask why any form of treatment is recommended. You may at any time refuse treatment or request a change in the treatment approach. Please discuss this further with your provider.

PROVIDER RESPONSIBILITY DISCLAIMER

Many insurance companies now require authorization for mental health services. It is your responsibility to notify the office if your insurance changes or if your insurance requires pre-authorization. However, it is your responsibility to be aware of the insurance company's preauthorization requirements and if your policy has plan limitations. Authorization for sessions does not guarantee available benefits. If benefits exhaust or preexisting conditions apply, you will be personally responsible for the bill. Payment is due within 30 days of mailing of billing statement notice.

GRIEVANCE PROCEDURES:

If you feel your rights have been violated please discuss this with your provider. If you are not able to resolve the issue in this manner, you may discuss it with the Business Office at (541)726-9912. Finally, if a grievance cannot be resolved in this manner, you should contact the Oregon State Board Medical Examiners or with the Secretary if the Department of Health and Human Services. You will not be penalized for filing a complaint.