Michelle T. Curry Pediatrics Patient Registration Form

PATIENT INFORMATION: **(ALL INFORMATION ON THIS FORM MUST BE COMPLETED)**

Patient: (Last, First MI) ____

Address: ______________________________ Date of Birth: ______________________________

______________________________ Home Phone: ______________________________

SS# ______________________________ Cell Phone: ______________________________

Male/Female **Race:** ____________ **Hispanic/Non-Hispanic/Declined** **Preferred Language:** ____________

School: ______________________________ **Pharmacy/Phone:** ______________________________

***Primary Contact Person:** Mother __ Father __ Other ___ ***Method of Contact:** Home _____ Work _____ Cell _____

Emergency Contact: ____________________ Phone: ____________________ Relationship: ____________________

PARENT INFORMATION: **(ALL INFORMATION ON THIS FORM MUST BE COMPLETED)**

Father's Name: ______________________________

Date of Birth: ______________________________

SS#: ______________________________

Address: (Check if Same as Pt ____)

____

Home Phone: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Work Phone: ______________________________

Employer: ______________________________

Mother's Name: ______________________________

Date of Birth: ______________________________

SS#: ______________________________

Address: (Check if Same as Pt _____)

____

Home Phone: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Work Phone: ______________________________

Employer: ______________________________

INSURANCE INFORMATION: **(ALL INFORMATION ON THIS FORM MUST BE COMPLETED)**

Primary Insurance: ______________________________ Who Holds Policy? ______________________________

ID#: ______________________________ Group#: ______________________________

Effective Date: ______________________________ Relationship: ______________________________

Subscriber's Date of Birth: ______________________________ **SS#:** ______________________________

Secondary Insurance: ______________________________ Who Holds Policy? ______________________________

ID#: ______________________________ Group#: ______________________________

Effective Date: ______________________________ Relationship: ______________________________

Subscriber's Date of Birth: ______________________________ **SS#:** ______________________________

I voluntarily give consent for my medical treatment or my child's medical treatment to the Providers at Michelle T. Curry Pediatrics. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

______________________________ ______________________________

Signature Date

Who can we thank for referring you to our practice?

Friend: ______________________________ **__Insurance** **____Website** **____Phonebook** **____Other**

Physician:

____

Name: ______________________________ **DOB:** ____________________

Date: ____________________ **Referred from:** ____________________

Age: __________ **Height:** ______________ **Weight (lbs):**__________ **Sex: Male / Female**

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?______________________________
2. Have you sought legal advice for this problem? ❑ Yes ❑ No

BIRTH/PEDIATRIC HISTORY (FOR PEDIATRIC PATIENTS ONLY):

Hospital & Location:______________________________

Delivery: ❑ Normal vaginal ❑ C-section Weeks in gestation? ❑ Full term ____#weeks ❑ Premature _____#weeks

Multiple birth (please check if appropriate): ❑ twins ❑ triplets ❑ quadruplets ❑ quintuplets ❑ other: ____________

Birth Weight: _______lbs or _______kg Immunizations:up to date ❑ Yes ❑ No

Complications of pregnancy?(please specify ay problems which medication was used for)

____

Infant pass his hearing screen at hospital? ❑ **Yes** ❑ **No** Did the mother use prenatal care? ❑ **Yes** ❑ **No**

Any hospitalizations: ❑ Yes ❑ No if so, for how long _____ days/weeks/months Why? ____________

Any treatments at birth: ❑ Yes ❑ No Please list ______________________________

____

Any history of intubation or needing to be connected to a breathing machine? ❑ Yes ❑ No How long? ________

History of jaundice requiring light therapy? ❑ Yes ❑ No Social or behavioral issues? ____________

Academic/school issues? ____________ Attends Daycare? ❑ yes ❑ no

PAST MEDICAL HISTORY

Neurologic

❑ Alzheimer's disease
❑ Multiple sclerosis
❑ Bell's palsy
❑ Stroke/mini-stroke
❑ Parkinson's disease
❑ Seizures
❑ Migraines
❑ Chronic headaches

Eyes/Ear/Nose/Throat

❑ Glaucoma
❑ Cataracts
❑ Hypothyroidism
❑ Hyperthyroidism
❑ Thyroid disease
❑ Laryngitis
❑ Recurrent tonsillitis
❑ Reflux
❑ Recurrent sinusitis
❑ Cholesteatoma
❑ Vasomotor rhinitis
❑ Otitis media/externa
❑ Allergic rhinitis
❑ Parotid swelling, recurrent
❑ Chronic cough
❑ Sleep apnea/snoring
❑ Otosclerosis
❑ Recurrent ear infections

Pulmonary/Cardiovascular

❑ High blood pressure
❑ Abnormal EKG/heart rhythm (____________)
❑ Heart aneurysm
❑ Carotid disease
❑ Coronary artery disease
❑ Asthma/Bronchitis
❑ Emphysema
❑ COPD
❑ Angina
❑ Heart disease
❑ Enlarged heart
❑ Peripheral vascular disease
❑ Valvular disease/murmur please specify ____________
❑ Congestive heart failure (CHF)
❑ High/low cholesterol (circle one)
❑ Heart attack
❑ Pneumonia
❑ Chronic cough

Musculoskeletal

❑ Juvenile Rheumatoid arthritis
❑ Joint disease
❑ Gout
❑ Neck/back disease
❑ Autoimmune disease
❑ Carpal tunnel syndrome
❑ Anemia
❑ Frequent falls
❑ Juvenile Rheumatoid arthritis

Infectious Disease

❑ Sexually transmitted disease please specify ____________
❑ Measles
❑ Mumps
❑ Rheumatic fever
❑ Scarlet fever
❑ AIDS
❑ Rubella
❑ Chicken pox
❑ Recurrent *Strep* infections

Endocrine/Psychiatric/Misc

❑ Diabetes- non-insulin dependent
❑ Diabetes – insulin-dependent
❑ Chronic fatigue
❑ Osteoporosis
❑ Schizophrenia
❑ Anxiety
❑ Attention Deficit Disorder
❑ Panic attacks
❑ Bipolar disorder
❑ Bleeding disorder
❑ Depression

Gastrointestinal/Genitourinary

❑ BPH
❑ Hiatal hernia
❑ Gall bladder disease
❑ Irritable bowel syndrome
❑ Kidney disease/stones
❑ Hepatitis (please specify _________)
❑ Peptic ulcer disease

❑ Cancer (including skin): ______________________________

❑ Skin condition (i.e., vascular marking, rosacea, psoriasis, eczema): ______________________________

❑ Other: ______________________________

Any genetic syndrome: ______________________________

Any spinal disorder: ______________________________

❑ Smoke, second hand exposure ❑ Yes ❑ No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them): ❑ None

a) Medication____Reaction____

b) Foods____Reaction____

c) Non Drug Allergies____

d) Does your child have a history of anaphylaxis? ❑ Yes ❑ No

e) Does your child have an allergy to latex? ❑ Yes ❑ No

f) Does your child have a history of a transfusion reaction? ❑ Yes ❑ No

FAMILY HISTORY (Check all illnesses that run in your family): ❑ None

❑ Alcoholism ❑ Allergies/hayfever ❑ Alzheimer's Disease ❑ Anemia
❑ Anemia, Sickle cell ❑ Anxiety, Sickle cell ❑ Arthritis ❑ Asthma
❑ Breast Cancer ❑ Colon Polyps ❑ Colon/rectal Cancer ❑ COPD/ emphysema
❑ Coronary Artery Disease ❑ Crib death or SIDS ❑ Degenerative joint disease
❑ Depression ❑ Diabetes ❑ Gallbladder disease ❑ Hearingloss
❑ Heart attack(s) ❑ Kidney Stone ❑ Melanoma ❑ Mental Illness/Suicide
❑ High blood pressure ❑ High Cholesterol ❑Migraines
❑Osteoporosis ❑Other ___________________ ❑ Parkinson's Disease ❑ Poor Circulation
❑ Stroke ❑ Thyroid Cancer ❑ TIAs – Transient ischemic attacks
❑ Thyroid Disease (high-hyperthyroidism) ❑ Thyroid disease (low-hypothyroidism)

Syndrome, genetic (please specify) ____

Cancer (please Specify)____

❑ Does not know family history, patient adopted

PAST SURGICAL HISTORY (Please check any surgeries you have had): ❑ None

❑ Adenoidectomy ❑ Aneurysm ❑ Appendectomy ❑ Back Surgery
❑ Carotid endarterectomy ❑ Cataract Excision ❑ Cholecystectomy
❑ Colon Surgery ❑ Colostomy ❑ Coronary artery bypass
❑ Ear surgery- ear drum repair (tympanoplasty) ❑ Ear Surgery – mastoid surgery (mastoidectomy)
❑ Brain surgery ❑ Tonsillectomy ❑ Rhinoplasty ❑ Septoplasty
❑ Sinus surgery ❑ Sinus surgery (please specify) ____
❑Thyroidectomy, total ❑ Tonsillectomy ❑ Tonsillectomy and adenoidectomy (T&A)
❑ Turbinate reduction ❑ P.E.T (ear tubes)
❑ Transplant (please specify, body part and when?) ____
Other ____

Describe any complications related to surgery: ____
____

Describe any complications related to anesthesia: ❑ None ❑ Nausea ❑ Vomiting ____________________
____

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL

❑ Weight loss________pounds in the past _____weeks ❑ Fever, chills ❑ Night sweats ❑ **None**
❑ Fatigue ❑ Loss of appetite

EYES:

❑ Wears glasses ❑ Blurring of vision ❑ Redness ❑ Other:
❑ Wears contacts ❑ Swelling ❑ Itchy eyes ____________________
❑ Blindness ❑ Dryness of eyes ❑ Double vision
❑ Watery eyes ❑ Eye pain ❑ Discharge ❑ **None=**

ENT: ❑ **None** ❑ Other ____

❑ Allergies ❑ Ear pain ❑ Hearing loss ❑ Nosebleeds ❑ Snoring
❑ Bleeding gums ❑ Facial pain ❑ Heartburn ❑ Nose pain ❑ Sore throat
❑ Decreased/lost smell ❑ Gum disease ❑ Hoarseness ❑ Septal perforation ❑ Sores on lips/gums
❑ Dentures ❑ Facial pain ❑ Mouth sores ❑ Teeth problems ❑ Voice changes
❑ Difficulty swallowing ❑ Gum disease ❑ Nasal congestion ❑ Postnasal drip ❑ Throat pain
❑ Dizziness/vertigo ❑ Headaches ❑ Nasal discharge ❑ Rhinorrhea ❑ Bad breath/taste
❑ Ear drainage ❑ Hearing aids ❑ Nasal obstruction ❑ Ringing in ears/tinnitus

Name: ____

CARDIOVASCULAR:
❑ Shortness of breath (at rest) ❑ Palpitations ❑ None
❑ Shortness of breath (exertion) ❑ Chest pain/pressure ❑ Other: ______________________________

PULMONARY/RESPIRATORY
❑ Cough ❑ Coughing blood (hemoptysis) ❑ Shortness of breath
❑ **None** ❑ Other: ____

GASTROINTESTINAL:
❑ Abdominal pain ❑ Change in bowel habits ❑ Nausea and vomiting ❑ Diarrhea
❑ Vomiting blood (hematemsis) ❑ Use of antacids ❑ Blood in stool
❑ **None** ❑ Other: ____

GENITOURINARY:
❑ Blood in urine (hematuria) ❑ Hesitancy ❑ Nocturia ❑ Wets bed (enuresis)
❑ **None** ❑ Other: ____

MUSCULOSKELETAL:
❑ Back pain ❑ Neck pain ❑ Weakness ❑ **None** ❑ Other: ______________________________

SKIN:
❑ Acne ❑ Itching ❑ Birth marks ❑ Loss of hair ❑ Change in mole
❑ Skin rashes ❑ Dryness ❑ **None** ❑
Other:______________________________________

NEUROLOGICAL:
❑ Memory loss ❑ Paralysis of arm or leg ❑ Speech difficulty ❑ Paresthesia
❑ Syncope ❑ Head trauma ❑ Near syncope ❑ Local weakness
❑ Numbness ❑ **None** ❑ Other: ____

PSYCHIATRIC:
❑ Disturbing thoughts/feelings ❑ Suicidal thoughts ❑ Hallucinations ❑ **None** ❑ Other: _______________

ENDOCRINE
❑ Heat or cold intolerance ❑ Thyroid nodule ❑ Hair loss ❑ Increased thirst
❑ **None** ❑ Other: ____

HEMATOLOGY/LYMPHATIC: ❑ Abnormal bleeding ❑ Easy bruising ❑ **None**
❑ Are you currently being anticoagulated? ❑ Yes ❑ No ❑ Enlarged lymph nodes

ALLERGY/IMMUNOLOGY
❑ Itchy eyes ❑ Red eyes ❑ Sneezing ❑ Hayfever
❑ Itchy nose ❑ Swollen eyes ❑ Urticaria ❑ Eye discharge
❑ Rashes ❑ **None** ❑ Other: ____

DO YOU HAVE ANY IMPLANTABLE DEVICES? If so, what and where? ______________________________

MEDICATIONS (List all your current medications and the dose you take): ❑ None (please use back if needed)
Medication____________________________________Dose____
Medication____________________________________Dose____
Medication____________________________________Dose____
Do you take Aspirin or Ibuprofen? ❑ Yes ❑ No
Do you take Warfarin (Coumadin) /Plavix ? ❑ Yes ❑ No Have you taken steroids within the past year? ❑ Yes ❑ No

Thank you for your cooperation

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION: *MEDICAL RECORD RELEASE*

Please fill out the following information about your prior doctor's office

AT MY REQUEST, I AUTHORIZE: ____ (Practice Name)
____ (Address)
_______________________________ (Phone) __________________________________ (Fax)

TO DISCLOSE THE FOLLOWING INFORMATION: any and all of the medical records pertaining to the treatment of ______________________________ (Patient Name) ____/____/_______ (Date of Birth), last seen on ____20____ (Date Last Seen)

DISCLOSE TO: M.T.CURRY INC (Michelle T. Curry M.D.)
733 VOLVO PARKWAY, SUITE 200
CHESAPEAKE, VA 23320
PH: 757- 547- 5851
FAX: 888-371-4920

PURPOSE OF DISCLOSURE: At the request of the individual/legal guardian:
____
____

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I understand that I have the right to revoke this Authorization at any time, except to the extent action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. *(The written revocation must be legible and include the name and date of birth of the individual, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to the receive the information, the signature of the person with legal authority for authorization/revocation, and if not the individual, a description of their legal authority for authorization/revocation, and their phone number.)*

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event or condition:
____
____

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

____ ____________
Signature of Patient/Parent/Legal Guardian Date

Michelle T. Curry Pediatrics

Do you have any other children with us?

If yes, please list them below. If not then you may skip this page of the registration form.

Name: ____ Date of Birth: ____/____/__________

(Last, First, Middle Initial)

Name: ____ Date of Birth: ____/____/__________

(Last, First, Middle Initial)

Name: ____ Date of Birth: ____/____/__________

(Last, First, Middle Initial)

Name: ____ Date of Birth: ____/____/__________

(Last, First, Middle Initial)

Name: ____ Date of Birth: ____/____/__________

(Last, First, Middle Initial)

Name: ____ Date of Birth: ____/____/__________

(Last, First, Middle Initial)

Michelle T. Curry Pediatrics

AUTHORIZATION TO GIVE CONSENT FOR OUTPATIENT MEDICAL TREATMENT

Child/Patient Name(s):	Date of Birth:

Until revoked by me in writing, the following persons are authorized to act on my behalf:
(1) to give consent to medical and/or diagnostic treatment in M.T. CURRY PEDIATRICS of my child named above;
(2) to give consent for testing my child's blood for HIV antibodies in accordance with the laws of Virginia which authorize health care providers to test patients when a health care provider is exposed to the body fluids of a patient;
(3) to assign benefits of third party payors for direct payment to M.T. CURRY PEDIATRICS
(4) to receive financial information regarding my child's health care and/or medical information about my child's condition, treatment or health care received at M.T. CURRY PEDIATRICS.

I agree that the following persons, 18 years of age or older, are authorized to sign on my behalf thus acknowledging the following statement and binding me to its terms in my absence: The undersigned parent and/or legal guardian agree that in consideration of services rendered to the patient, each of them jointly and severally, will pay and guarantee payment to M.T. CURRY PEDIATRICS. I furthermore irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to M.T. CURRY PEDIATRICS for services rendered. I understand my insurance policy is a contract between my insurance company and me, and I am responsible to M.T. CURRY PEDIATRICS for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand I will receive a separate statement and bill from the laboratory or radiology department performing the test. If all charges are not paid when due to M.T. CURRY PEDIATRICS, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed THIRTY-THREE AND ONE-THIRD PERCENT (33-1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral.

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of $35.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. Please direct all billing inquiries to the M.T. CURRY PEDIATRICS Billing Representative where you received your care.

AUTHORIZED PERSONS:

______________________________ ______________ ____________________
FIRST NAME LAST NAME PHONE RELATIONSHIP TO CHILD

______________________________ ______________ ____________________
FIRST NAME LAST NAME PHONE RELATIONSHIP TO CHILD

______________________________ ______________ ____________________
FIRST NAME LAST NAME PHONE RELATIONSHIP TO CHILD

____ ____________________
Parent/Legal Guardian Date

____ ____________________
Witness Date

733 Volvo Parkway, Suite 200
Chesapeake, VA 23320
Phone (757) 547-5851 Fax (888) 371 9223

Michelle T. Curry Pediatrics

Insurance Waiver

As a courtesy to our patients, we accept most insurance carriers and are glad to process your claims for you. We are not obligated to do so. It is the patient's (parent or guardian if the patient is under age) to make sure that the following things are understood.

- **It is the responsibility of the guarantor(s) to understand what the insurance policy covers.** If unsure of what the policy entitles you to, please refer to your insurance contract or contact the insurer prior to being seen.
- **If the patient does not have insurance or the policy provided does not cover certain procedures, then payment is due at time of service.** This is at our discretion and/or the discretion of the insurance company.
- **Be sure to notify us of any insurance company changes, new births or any changes of address as soon as upon check-in.** Please follow up with the insurance company to ensure that your child is covered after being discharged from the hospital. Most insurance companies will not add a child until they hear from the policy holder.
- **In the case of newborns, some private insurers DO NOT backdate the policy to the child's date of birth.** In such cases the parent may be held responsible for any services rendered as the child may not be covered. Please check with your insurance company and ask what their particular rules concerning new births are.
- **If the patient is enrolled in an HMO, please notify the insurance company that Dr. Michelle T. Curry is the primary care physician (PCP).** If this isn't done prior to the date of service, the insurance company may deny payment of the claim, at which time the guarantor(s) will be held responsible for the payment or the appointment will be rescheduled.
- **All copays are due at the time of visit. Co-insurance and deductibles will be billed to the guarantor(s) after we bill the insurance company and receive the EOB stating what the patient responsibility is. Any balances unpaid by the insurance company the responsibility of the guarantor(s). This includes co-pays, deductibles, co-insurance and any other fees not covered by the insurance policy.**
- **We accept cash, checks, MasterCard, VISA and Discover Card. There is a fee for any returned checks.**
- **If balances are not paid in a timely manner, the account will be referred to collections or a collections attorney. Parents will be responsible for payment of all attorney's fees, collection agency fees or any other fees associated with collecting any outstanding balance to include outstanding principal balances, interest, late fees, court costs and filing fees, postage and handling fees, or courier fees.**
- **Missed appointments that are not cancelled within a 24-hour window, will result in a $25.00 no show fee. Insurance does not cover this fee.** After 4 consecutive no shows the patient will be discharged from the practice. If for any reason an appointment must be cancelled, please call to reschedule as soon as possible.

I have read and understand the above information and agree to said terms and conditions.

________________________________ ________________________________

Printed Name Date

____

Signature

733 Volvo Parkway, Suite 200
Chesapeake, VA 23320
Phone: (757) 547-5851 | Fax: 1 (888) 371-4920

Michelle T. Curry Pediatrics

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.

If you have any questions about this Notice please contact the Privacy Officer at 757-547-5851.

Effective Date: April 14, 2003 Revised: May 6, 2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report the gunshot wounds or suspected abuse or neglect.

- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners & Funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers ' compensation laws and other similar legally- established programs.

Other uses and disclosures of your health information:

- Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may disclose your PHI to the following unless you object:

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of you PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms , prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the Authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. The Office Manager privacy Officer can will have the form for you to fill out.

NOTICE OF PRIVACY PRACTICES

You have the right to see and obtain a copy of your PHI.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction al your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

> **There is one exception:** we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

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Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints
If you think we have violated your rights or you have a complaint about our privacy practices you can contact: Operations Manager- Eric Curry 757-547-5851

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint. This notice was published and becomes effective on May 6, 2013.