CardioVascular Solutions Institute

Patient Registration

Patient Information

First Name:	Middle Initial:	Last Name:	Age:	DOB: / /
SSN: - -	Gender: M / F	Home Phone: Check the box of the Primary Phone Number ☐		
Billing Address:		Work Phone: ☐		
City, State & Zip:		Cell Phone: ☐		
Email:		Race/Ethnicity: Black Hispanic White Other:		
Religion:		Primary Language:		
Primary Physician:		Referring Physician:		

Out of State Address

Address:	Phone Number:
City, State & Zip:	

Insurance Information

PRIMARY INSURANCE		Subscriber:	DOB: / /
Address:		Policy ID:	Group:
City, State & Zip:			
Plan Phone #:		Patient Relationship to Subscriber:	
SECONDARY INSURANCE		Subscriber:	DOB: / /
Address:		Policy ID:	Group #:
City, State & Zip:			
Plan Phone #:		Patient Relationship to Subscriber:	

Parent/Legal Guardian/Spouse & Emergency Contact Information

Parent/Legal Guardian/Spouse Name:	Emergency Contact:
Relationship to Patient:	Relationship to Patient:
Home Phone: Other Phone:	Home Phone: Other Phone:

Medical Authorizations & Release of Information

I hereby authorize CardioVascular Solutions Institute to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize CardioVascular Solutions Institute to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

x_____ _____

Signature Date

CardioVascular Solutions Institute

Patient Registration

Payment of Services, Insurance Benefits, Authorization to Release/Obtain Information

I hereby authorize CardioVascular Solutions Institute, A Medical Corporation to obtain any medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any medical records concerning my care to any physician, hospital or other health care professional currently providing care to me. Additionally, I authorize the Practice to release any medical records concerning my care to my medical insurance company (i.e. Medicare, Medicaid, and insurance company, third party administrator, or managed care company) except as specifically provided: _____.

I am aware that the records may contain information relating to psychiatric or psychological testing, physical abuse and/or alcohol abuse and/or HIV test results, if any.

I realize that I am responsible for payment of all medical service rendered to me, regardless of the decision regarding reimbursement made by my insurance carrier. If I am not eligible or services rendered are not covered benefits under the terms of my Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered.

x_____ _____
Signature Date

By **refusing to sign the above, I understand that my insurance company will not be billed by CardioVascular Solutions Institute and I am responsible for payment at the time of service. **

x_____ _____
Signature Date

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with the members of your family or other individuals (someone other than yourself or your doctors) that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize the Practice to release verbally and/or photo copies of any or all medical and billing information, pertaining to my medical care, to the following family members or individuals: I understand this information may only be released to the individual after proper identification has been presented to the office. The authorized person may be requested to obtain this information by appearing in person at the office.

☐ I **do not authorize** the Practice to release any or all information concerning my medical care to any individual except as set forth above.

☐ I **authorize** the Practice to release verbally and/or photocopies of any or all information concerning my medical care (appointments, prescriptions, etc) to the following individuals:

_____ _____
Name Phone #

_____ _____
Name Phone #

_____ _____
Name Phone #

x_____ _____
Signature Date

Witness (office use only): _____ Date: _____

CARDIOVASCULAR SOLUTIONS

Date:_____

HEALTH HISTORY

Name:_____DOB:_____

Referring Doctor:_____ Primary Doctor:_____

Why are you seeing a cardiologist? _____

History and Physical – Please (X)

Heart problems or symptoms:

- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Abnormal Rhythm (arrhythmia)
- ☐ Palpitations, irregular heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest Pains or Pressure
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Swollen Legs
- ☐ Heart Failure
- ☐ Blue Lips or Fingernails
- ☐ Leg Cramps when you walk

Have you ever had:

- ☐ Stress Test (Treadmill)
- ☐ Echocardiogram
- ☐ Cardiac Catheterization
- ☐ Coronary Angioplasty (balloon)
- ☐ Coronary Bypass Surgery
- ☐ Valve Surgery
- ☐ Electrophysiology Study/Proc.
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ EKG
- ☐ 24 Holter Monitor
- ☐ 30 Day Event Recorder

Check if you have:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Ever Smoked
- ☐ Diabetes
- ☐ Do you exercise (walking)

Close family member with:

- ☐ Heart Attack
- ☐ Mother ☐ Father

If a Woman have you:

- ☐ Passed Menopause
  if so what age: ____
- ☐ Take Estrogen replacement

Please tell us anything else about your heart: _____

Current Medications:

(Include over-the-counter medications)

Name of Medication	Strength	Times per Day

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No

List medications to which you are allergic: _____

What kind of reaction did you have? _____

Past Medical History – Please (X) any symptoms you have or have had in the past year.

Constitutional

- ☐ Lack of energy
- ☐ Trouble sleeping
- ☐ Loss of Appetite
- ☐ Weight changes
- ☐ Fever

HEENT

- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Buzzing or ringing in ears
- ☐ Hay fever
- ☐ Sinus Problem

Respiratory

- ☐ Wheezing
- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Tuberculosis

OVER >>

HEALTH HISTORY Continued:
Name: _____

Digestive
- ☐ Indigestion
- ☐ Change in bowel habits
- ☐ Bloody or tarry stools
- ☐ Jaundice
- ☐ Liver problems
- ☐ Ulcers Gallstones

Dermatological
- ☐ Rash
- ☐ Itching
- ☐ Other skin problems

Neurological
- ☐ Paralysis (even temporary)
- ☐ Stroke
- ☐ Numbness
- ☐ Loss of balance
- ☐ Dizziness

Hematological
- ☐ Bleeding
- ☐ Easy bruising

- ☐ Risk Factors for HIV
- ☐ Anemia
- ☐ Cancer

Urinary
- ☐ Frequency
- ☐ Infections
- ☐ Stones
- ☐ Bladder incontinence

Men
- ☐ Prostate problems
- ☐ Night-time urination

Women
- ☐ Abnormal Menstrual Periods
- ☐ Could you be pregnant?

Psychiatric
- ☐ Unusual thoughts
- ☐ Nervousness
- ☐ Crying or sadness
- ☐ Depression
- ☐ Suicide attempts

Musculoskeletal
- ☐ Joint pain, swelling or redness
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle aches
- ☐ Muscle tenderness
- ☐ Gout

Female Reproductive
- ☐ Breast lumps Recent
- ☐ Mammogram
- ☐ Pap Smear &/or Pelvic Exam

Endocrinology
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Excess thirst
- ☐ Excess hunger
- ☐ Excess urination

Have you had any operations?
Please include dates.
1) _____ 2) _____
3) _____ 4) _____

Are you being treated now or have been treated for any illness?
1) _____ 2) _____
3) _____ 4) _____

Social History:

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced
With whom do you live? _____
Occupation _____
Leisure Activities _____
_____
Education Level _____

Health Habits:
Do you smoke? ☐Yes ☐No
How many packs per day? _____
For how many years? _____
How much alcohol do you drink? _____
Do you use any drugs? _____

Family History:
Check if any close family members (parents, brothers and sisters, children) have:

☐ Heart Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child

Are there any other health problems in your family? _____
_____

Hospitalizations:

Year	Hospital	Reason

CARDIOVASCULAR SOLUTIONS INSTITUTE

Gino Sedillo, MD, FACC, FACP

Phone: (941) 747-8789
Fax: (941) 747-8711

ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____
Signed Print Name

_____ _____
Date Telephone

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and address of Patient: _____

_____

_____

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENTS TRACKING INFORMATION

For Office Use Only:

Date received: _____ Processed by: _____

Practice Follow-up: (please circle) Yes No Date of Practice Follow-up: _____

Complete the following only if the patient refused to sign the acknowledgment:

Efforts to obtain: _____

Reasons for refusal: _____

CARDIOVASCULAR SOLUTIONS INSTITUTE

Gino Sedillo, MD, FACC, FACP

2210 61st St W, Bradenton, FL 34209
Phone: (941) 747-8789
Fax: (941) 747-8711

MEDICAL RECORDS RELEASE

Name: _____ SSN: _____ Date of Birth: ___/___/_____

Address:_____ Phone #: _____

CardioVascular Solutions may OBTAIN copies of my medical records listed below from:

1.(Physician or facility which has health information)
Name:_____
Address: _____
_____
Phone: _____ Fax: _____

2.(Physician or facility which has health information)
Name:_____
Address: _____
_____
Phone: _____ Fax: _____

CardioVascular Solutions may RELEASE copies of my records listed below from:

1.(Physician or facility which has health information)
Name:_____
Address: _____
_____
Phone: _____ Fax: _____

2.(Physician or facility which has health information)
Name:_____
Address: _____
_____
Phone: _____ Fax: _____

Consultation (date)_____ Event Recorder (date)_____ Holter (date)_____

Progress Note (date)_____ Hospital Records (date)_____ Cath/PCI (date)_____

Stress Echo (date)_____ Echocardiogram (date)_____ EKG (date)_____

Nuclear Stress (date)_____ Lab Reports (date)_____ Copy ALL Records (up to 7 years)

Other_____

I AUTHORIZE THE RELEASE OF ALL INFORMATION AND I AM AWARE THAT THE RECORDS RELEASED MAY CONTAIN CONFIDENTIAL INFORMATION RELATING TO PSYCHIATRIC OR PSYCHOLOGICAL TESTING, PHYSICAL ABUSE OR DRUG/ALCOHOL ABUSE.

☐ CHECK HERE TO EXCLUDE CONFIDENTIAL INFORMATION

_____ _____ _____
Patient's Signature Date Signature of Witness

*If individual is unable to sign this authorization, please complete the information below:

_____ _____ _____
Name of Guardian/Representative Legal Relationship Date

THIS AUTHORIZATION EXPIRES THREE YEARS AFTER DATE SIGNED
THE INFORMATION CONTAINED HEREIN IS PROHIBITED FOR USE OTHER THAN THE STATED PURPOSE

CARDIOVASCULAR SOLUTIONS INSTITUTE

Gino Sedillo, MD, FACC, FACP

Phone: (941) 747-8789
Fax: (941) 747-8711

Date: _____

Dear: _____

Your appointment has been scheduled for _____

at _____a.m./p.m. We are located at **2210 61st St W, Bradenton, FL 34209.**

Enclosed you will find the registration forms we need for your appointment. You should complete all the information and bring these forms with you to the appointment. Please arrive to our office to check in 15 minutes prior to your appointment. If you have NOT completed your paperwork, please arrive 30 minutes prior to your appointment.

Please sign below to acknowledge that your appointment will be rescheduled if you arrive more than 10 minutes past your appointment time.

_____	_____	_____
PRINT	**SIGNATURE**	**DATE**

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

- ☐ Completed patient registration forms (note: medical history form is front and back)
- ☐ Health insurance card and photo identification.
- ☐ List of medications you are currently taking.
- ☐ Any past medical records
- ☐ Referral from your Primary Care Physician, if required by your insurance plan
- ☐ Copay, unmet deductible and coinsurance, or payment in full (we accept all major credit cards, check, or cash)

PLEASE NOTE: ALL COPAYS, DEDUCTIBLES AND COINSURANCE ARE DUE AT THE TIME OF SERVICE.

You will receive a call from our office 3 days prior to your appointment to confirm. Appointment must be confirmed.

If you must cancel or reschedule your appointment, please call our office (941) 747-8789 at least 24 hours prior to your scheduled appointment.

Thank you,
Cardiovascular Solutions Institute

CARDIOVASCULAR SOLUTIONS INSTITUTE

Gino Sedillo, MD, FACC, FACP

Phone: (941) 747-8789
Fax: (941) 747-8711

OFFICE POLICIES

Office Hours: Monday-Thursday 8AM to 4:30PM, Friday 8AM to 3PM. The Doctor on call after office hours is available only for urgent medical issues. In the event of an emergency, you should call 911 or go to the nearest hospital.

Appointments: Please inform our front office staff of any changes of insurance, phone number, or address. If you are unable to keep your scheduled appointment, please call our office no less than 24 hours in advance to reschedule or cancel. If you miss an appointment, and do not call to cancel, you may be dismissed from the practice. If you are more than 10 minutes late for an appointment, you may be asked to reschedule.

Telephone/Online Messages: Non-urgent messages will be returned by the end of the day. If you have an urgent problem, please speak with a nurse (do NOT leave a message). Please allow up to 48 hours to process prescription refill requests. Disability and other insurance forms may take 1 week for completion.

Medical Records: Medical records will be released to you with a signed request. The charge is $0.25 per page with a maximum charge of $10.00.

Financial Policies: Co-pays, deductibles, coinsurance, and any outstanding balance are due at the time of service. Any financial hardship or payment plans must be addressed prior to the appointment. Please make sure any required authorizations and/or referrals are obtained prior to your appointment.

Overdue Balances: By default, patient accounts are flagged for collections when all of the following criteria are met:

- 10 days since the last patient statement was mailed.
- At least 3 statements have been mailed to the patient.
- The minimum balance is more the $4.99.

CARDIOVASCULAR SOLUTIONS INSTITUTE

Gino Sedillo, MD, FACC

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous. usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The practice reserves the right to change the privacy policy as allowed by law.
3. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family or friend? YES NO
If YES, please list the name and contact number below.

_____

_____

This consent was signed by:

_____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____

CARDIOVASCULAR SOLUTIONS INSTITUTE, LLC
2210 61st St W,
BRADENTON, FLORIDA 34209
941-747-8789

Privacy Officer: PRACTICE MANAGER

Effective Date: 11-01-11

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- Health oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction{s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions {except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restrictions(s).

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy, You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on tile and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve {12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

☐ A brief description of what happened;
DA description of the health information that was involved;
D Recommended steps you can take to protect yourself from harm;
☐ What steps we are taking in response to the breach; and,
D Contact procedures so you can obtain further information.

Right to Opt-Out of Fundraising Communications. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email tor fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.