NORTHEAST FLORIDA INTERNAL MEDICINE
Elyssa Blissenbach, MD, PA
2065 Herschel Street
Jacksonville, Florida 32204
904-387-4050

PATIENT INFORMATION SHEET

Name: _____ SSN: _____
First M.I. Last

Date of Birth: _____ Male: _____ Female: _____

Single: _____ Married: _____ Widowed: _____ Divorced: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Spouse's Name: _____ Work Phone: _____

Referred By: _____ Address: _____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

In case of emergency notify: Name: _____ Phone Number: _____

Email: _____ Referred By: _____

PLEASE READ THE FOLLOWING AUTHORIZATION AND SIGN:

I hereby authorize my insurance benefit to be paid directly to Elyssa A. Blissenbach, M.D., P.A. for any services furnished to me I acknowledge financial responsibility for non-covered service. I also authorize the physician to release any information required to process this claim.

Patient's Signature _____ Date: _____

Patient Name: _____ DOB: _____

SURGICAL HISTORY: (Please list all surgeries with approximate date):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Describe your current state of health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY:

	Father	Mother	Brother	Sister	Grandparent
Living? Check if "yes"	☐	☐	☐	☐	☐
History Unknown	☐	☐	☐	☐	☐
Heart Attack, bypass surgery, angioplasty before age 55	☐	☐	☐	☐	☐
Heart Attack, bypass surgery, angioplasty After age 55	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Elevated cholesterol or triglycerides or low HDL	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Other Cancer / Malignancy	☐	☐	☐	☐	☐
Arthritis, any type	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

SOCIAL HISTORY: Martial Status: Single Married Separated Divorced Widow(er)
Occupation: _____ Current Employer: _____

How much caffeine (coffee, tea, sodas, etc.) do you drink? Number of servings per day? ____ Per week? ____
How much alcohol do you drink? Number of drinks per day? ___ Per Week? ___ Per Month? ___ for ___ years
Do you use tobacco? No Yes Cigarettes Cigar Snuff/Chew When did you quit? _____
Number of packs per day? _____ Number of years you smoked? _____
Have you ever used marijuana, cocaine, or other drugs? No Yes

REVIEW OF SYSTEMS

Patient Generated

Patient Name: _____ Date: _____

Check either yes or no for each item except where applies to only male or female.

	Conditions	Yes	No
GENERAL	Fever		
	Chills		
	Bruise Easily		
	Swollen Glands		
	Loss of Memory		
	General Weakness		
	Aches/Pains		
ENT	Double Vision		
	Light Flashes		
	Blurred Vision w/o Glasses		
	Halos Around Lights		
	Eye Pains		
	Ear Pains		
	Buzzing/Ringing in Ears		
	Nose Bleeds		
	Sinus Problems		
	Swallowing Problems		
	Deafness		
	Mouth/Tooth/Tongue Problems		
	Persistent Hoarseness		
	Severe Headaches		
	Other*		
SKIN	Rash		
	Changing Moles		
	Pigmentation		
	Other Skin Problems		
CHEST/ HEART / LUNGS	Irregular Heart Beat		
	Shortness of Breath		
	Low Exercise Tolerance		
	Heart Flutters		
	Chest Pains		
	Frequent Cough		
	Cough up Blood		
	Wheezing		
	Night Sweats		
	Swollen Ankles		
	Cramps in Legs		
	Other*		

	Conditions	Yes	No
NECK	Stiffness		
	Swelling		
	Lumps		
	Other		
GASTROINTESTINAL	Appetite Poor		
	Indigestion/Heartburn		
	Nausea		
	Vomiting Blood		
	Abdominal Pain/Cramps		
	Abdominal Tension		
	Diarrhea		
	Constipation		
	Bowel Changes		
	Rectum Blood		
	Black Tar-Type Movements		
	Other*		
KIDNEY	Up Nights to Urinate		
	Blood in Urine		
	Burning or Pain while Urinating		
	Problem Urinating		
	Trouble Controlling Urine		
	Other*		
MUSC	Leg/Arm Weakness		
	Balance Problems		
	Dizziness		
	Fainting Spells		
	Speech Problems		
	Other*		
BONE / JOINTS	Joint Pains		
	Joint Swelling		
	Muscle Strength Loss		
	Muscle Lump/Swelling		
	Lump on Bone		
	Pains in Back		
	Other*		
ENDOCRINE	Constant Thirst		
	Most Always Cold		
	Too Warm Most Times		
	Very Sluggish or Tired		
	Jumpy/Nervous		

	Conditions	Yes	No
PSYCHOLOGICAL	**Is your life:**		
	Satisfactory		
	Boring		
	Demanding		
	Unsatisfactory		
	Is there worry over		
	Home Life		
	Marriage		
	Job		
	Children		
	Money		
	Do you:		
	Often Feel Depressed		
	Have Irrational Fears		
	Feeling things go wrong often		
	Feel Upset		
	Feel Shy		
	Cry Easily		
	Feel Inferior		
	Have you:		
	Attempted Suicide		
	Seriously Considered Suicide		
MALE GENITALIA	Lump in Testicles		
	Penis Discharge		
	Breast Lump		
	Sore on Penis		
	Erection Difficulties		
	Other*		
FEMALE GENITALIA	Breast Lump		
	Nipple Discharge		
	Vaginal Discharge		
	Non-Period Bleeding/ Spotting		
	Hot Flashes		
	Pain with Intercourse		
	Possibly Pregnant		
	Change in Periods		
	Pain Other than with Periods		
	Other*		

Explain Other*:

Patients Name: _____ DOB: _____

PHYSICAL ACTIVITY:

1. How many **times per week** do you accumulate 30 minutes of daily activity such as walking, climbing stairs, raking leaves, or vacuuming/sweeping?
   Circle Number of days: None 1 2 3 4 5 6 7

2. How many **times per week** do you engage in cardiovascular (aerobic) exercise of at least 20-30 minutes duration such as brisk walking, cycling, jogging, swimming, active sports, etc.?
   Circle Number of Days None 1 2 3 4 5 6 7

PERSONAL HEALTH HISTORY:

Check each of the health conditions you have now or have had in the past. Please enter the approximate date of onset under each

Cardiovascular

- ☐ Heart Attack
- ☐ Angina
- ☐ Bypass Surgery
- ☐ Angioplasty
- ☐ Heart Valve Disease
- ☐ Heart Valve Surgery
- ☐ Pacemaker
- ☐ Defibrillator Implant
- ☐ Atrial Fibrillation
- ☐ Arrhythmias
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ TIA or "Mini-stroke"
- ☐ Carotid Blockage
- ☐ Leg Artery Blockage
- ☐ Angioplasty to Legs
- ☐ Abdominal Aneurysm
- ☐ Bypass Surgery to Legs
- ☐ Stent Placement in Heart
- ☐ Stent Placement in Legs

Pulmonary

- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Recurrent Pneumonia
- ☐ Pulm Hypertension
- ☐ Restrictive Disease
- ☐ Lung Cancer
- ☐ Tuberculosis
- ☐ Chronic Bronchitis

Psychosocial

- ☐ Depression
- ☐ Stress
- ☐ Anxiety
- ☐ Nervous Disorder

Musculoskeletal

- ☐ Arthritis
- ☐ Low Back Pain
- ☐ Back Surgery
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Other Joint Surgery
- ☐ Fibromyalgia
- ☐ Myofascial Palm
- ☐ Rotator Cuff Disorder
- ☐ Scailes
- ☐ Chronic Fatigue

Other Conditions

- ☐ Thyroid Disease
- ☐ Pancreatitis
- ☐ High Blood Pressure
- ☐ Polycystic Ovarian Syndrome
- ☐ Seizures
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Colon Cancer
- ☐ Other Cancer _____
- ☐ Bowel Polyps
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Disease
- ☐ Reflux (GERD)
- ☐ Stomach Ulcer
- ☐ Hepatitis
- ☐ Cirrhosis/Liver Disease
- ☐ Weight Loss or Gain
- ☐ Kidney Disease
- ☐ Protein in Urine
- ☐ High Cholesterol
- ☐ Retinopathy
- ☐ Neuropathy
- ☐ Recurrent Infections

☐ Other: _____

_____

_____

Patient Name: _____ DOB: _____

MEDICAL / VITAMINS / SUPPLEMENTS / BIRTH CONTROL

Name of Pharmacy: _____ Phone # _____

Do you send your prescriptions in to mail order? (Circle One) Yes No

If requesting refills, please indicate quantity needed (Circle One) 30 Days 90 Days

Please list all PRESCRIPTION MEDICATIONS:

NAME OF DRUG	DOSE	TIMES PER DAY

Name of Glucometer (Sugar Machine): _____

How often do you forget to take or miss your diabetes medication? _____

If you inject insulin, do you use insulin pens or vials? _____

Brand and size of syringes? _____

Please list the name and dose of all over-the-counter medications you currently take:

Vitamins / Minerals: _____

Dietary Supplements: _____

Aspirin: _____

Herbal Products: _____

Pain Relief Products: _____

ALLERGIES (Medications, Latex)? Please list type of reaction next to each allergy:

_____

_____

_____

_____

FINANCIAL POLICY

As your family practitioner, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

- **PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED**: We accept cash, personal checks, debit cards and credit cards. Returned checks are subject to a $35.00 service fee and you will lose your privilege to write checks.

- **PPO INSURANCE COVERAGE**: CO-PAYMENT and DEDUCTIBLE MUST VBE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies, we will file your insurance.

- **MEDICARE**: Your deductible and 20% of the allowable charges are due at the time of service, however, since we are a Medicare provider, we will file your Medicare. If we do not know the allowable charge for a specific service or deductible, you will be billed after payment is received from Medicare.

- **AUTOMOTIVE ACCIDENTS**: We will file your insurance claim when you are involved in an automobile accident, however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

- **LABORATORY BILLING PROCEDURE**: I have been informed that all laboratory procedures done outside of the office (blood work, cultures, PAP smears, etc.) will not be included in the charges for Elyssa Blissenbach, M.D., P.A. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Elyssa Blissenbach, M.D., P.A., will send my lab specimens to a laboratory that accepts my insurance.

- **NO SHOW POLICY**: Failure to show for a scheduled appointment will result in a $25.00 charge. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your appointment.

- **CONSENT FOR MEDICAL TREATMENT**: I am the patient or the patient's duly authorized representative and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary in the judgment of my physician of his/her designee for myself, my minor child or other. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

Signature: _____ Date: _____

ELYSSA BLISSENBACH M.D., P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND TO RELEASE SCRIPTS/MEDS

This form authorizes us to discuss your health with someone other than you. This form also authorizes us to release medications or prescriptions to other than you. Please provide us with their name, phone number, and relationship to you. It is your responsibility to provide us with their updated phone number and/ or any changes to this policy.

_____ It is o.k. to discuss my health/release medications/Scripts
_____ I do not want Dr. Blissenbach's staff to discuss my health nor release any meds or scripts to anyone.

Who can we talk to regarding your health?

Name	Phone Number	Relationship

Patient Name (PRINT): _____Date of birth_____

Patient Signature: _____Date:_____

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Elyssa Blissenbach, MD
2065 Herschel Street
Jacksonville, FL 32204
Phone: 904-387-4050, Fax: 904-387-4860

The charges listed below are not covered by any insurance plan and are the patient's responsibility:

- Office visit no-show fee $25.00
- Procedure no-show fee $50.00
- Letters written $25.00 (unless requested at time of a scheduled visit)
- Medical records $ 1.00 per page
- Disability/FMLA paperwork requires an office visit regardless of how recently seen

If a patient is in collections, they cannot be seen unless it is an emergency visit, until their account is brought current.

Please be advised if you come in for a non-scheduled visit which results in discussing any medical condition with a provider or medical personnel, you will be billed for an office visit.

PRINT NAME: _____

SIGN NAME: _____ DATE: _____

NORTHEAST FLORIDA INTERNAL MEDICINE
ELYSSA BLISSENBACH, M.D., P.A.

APPOINTMENT CANCELLATIONS

As a courtesy to your Doctor, Nurse Practitioner, and other patients, please give a 24 hour notice if cancelling or rescheduling your appointment. If you fail to give this notice, you will be charged a $25.00 late cancellation fee.

In the event you are charged this fee, you will be required to pay the amount before a future appointment(s) can be made.

By signing this, you are in agreement of this policy.

Signature: _____ Date: _____

PROCEDURE CANCELLATIONS

There will be a $50.00 cancellation fee per procedure of any procedures not cancelled within a 24 hour period. This also applies to no-shows.

By signing this, you are in agreement of this policy.

Signature: _____ Date: _____

ELYSSA BLISSENBACH M.D., P.A.

AUTHORIZATION TO LEAVE DETAILED VOICEMAIL

By signing this form, you authorize Dr. Blissenbach and her staff to leave a detailed message regarding your lab and/or test results on your answering machine or voicemail. It is your responsibility to provide us with your updated phone number and/or any changes to this policy.

Thank you for your cooperation.

Patient Name: _____

Patient Signature: _____

Best phone number(s) to call: _____

NORTHEAST FLORIDA INTERNAL MEDICINE
2065 Herschel Street
Jacksonville, Florida 32204

Authorization for Release of Medical Information

Patient Name:	Birth Date:
Social Security # (Last 4 digits only):	Telephone #
Address:	

I HEREBY AUTHORIZE: _____ and its affiliates and agents.
(Facility Name)

RELEASE THE FOLLOWING MEDICAL INFORMATION ABOUT ME TO:

Organization/Person Name: _____
Address: _____ Telephone # _____
City: _____ State: _____ Zip: _____

FOR THE FOLLOWING PURPOSE:

- ☐ Continued Care
- ☐ Legal Reasons
- ☐ Insurance
- ☐ Social Security Disability
- ☐ DCF
- ☐ Personal Life
- ☐ Other: _____

MEDICAL INFORMATION TO BE RELEASED:

Psychotherapy Notes. (If you are requesting Psychotherapy Notes, then you may not release any other information with this authorization and you may not check any of the other boxes in this section. To release your other records, you must submit a separate authorization.)

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Operative/Procedure Report
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Anesthesia Reports
- ☐ Emergency Department Record
- ☐ Other Medical Information: _____
- ☐ Complete Record (excluding Psychotherapy Notes, if any)

DATES OF SERVICE NEEDED:

- ☐ From _____ To _____
- ☐ All dates of service

FEE SCHEDULE: $1.00 per page — paper records up to 25 pages
$0.25 per page — paper records after 25 pages

NOTE: Fee will be waived if released to treating Doctor/Treatment Facility.

- I understand that the released information may include information relating to the diagnosis, treatment, and/or examination for **ALCOHOL**, and **DRUG USE; MENTAL HEALTH (psychiatry/psychology/psychotherapy)**; and **HIV (Human Immunodeficiency Virus)** and **AIDS (Acquired Immune Deficiency Syndrome).**
- I acknowledge that I am signing this authorization voluntarily.
- I understand that I may revoke this authorization in writing at anytime, except to the extent already relied upon and except as stated in Dr. Blissenbach's Notice of Privacy Practices. Also, patients who believe information in their medical record is incorrect or incomplete may request an amendment of patient information. To revoke this authorization or request an amendment, contact Dr. Blissenbach's office.
- The law prohibits recipients of this information without the specific written consent of the patient. However, I understand that Dr.Blissenbach cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer be protected by privacy laws once it has been so used or re-disclosed.
- The law prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members.
- This authorization expires twelve months from the date listed below and covers only dates of service for the dates specified above.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me.

_____ _____
Signature of Patient Signature of Patient's Authorized Representative

Date Description of Representative's Authority to act for Patient

Witness

INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request Dr. Elyssa Blissenbach, as my physician, and such associates, technical assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition which has been explained to me and documented in my chart. I hereby authorize and give my voluntary consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my diagnosis.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful. I further understand that these medication(s) are addictive and may produce adverse effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment at Northeast FL Internal Medicine. Those tests include initial and subsequent random unannounced urine and/or blood tests for drugs and I hereby give permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from Northeast FL Internal Medicine.

For Female patients only: To the best of my knowledge,

_____I am pregnant _____I am not pregnant

I understand that I must tell my physician immediately if I am pregnant, as the medications prescribed could have an adverse affect upon me and/or my unborn child.

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) for the treatment of my documented diagnosis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time.

I understand that no warranty or guarantee has been made to me as to result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines may reverse the action of the controlled substance I am using for my documented diagnosis.

CONTROLLED SUBSTANCES AGREEMENT: This informed consent also contains the following important requirements that I must fulfill in order to be treated with any controlled substances.

This agreement relates to my use of any controlled substance(s) (i.e., Narcotics, painkillers, prescription medications) for my documented diagnosis prescribed by Dr. Blissenbach's doctors and/or any appropriately authorized assistant(s) in his/her office(s). I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substance(s). The Florida Department of Health has specific requirements for the use of controlled substance(s).

Therefore, controlled substance(s) will only be provided so long as I adhere to the rules specified in this Agreement.

My doctor and/or any appropriately authorized assistants(s) may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and if the narcotics are not improving my quality of life the narcotics will be discontinued. I will disclose to Dr. Blissenbach and/or any appropriately authorized assistant(s), all drugs I take at any time, prescribed by any physician.

I must keep all follow-up appointments as recommended by my physician or my treatment and/or medication(s) may be discontinued.

I will use the medication(s) exactly as directed by my doctor and/or his/her appropriately authorized assistant(s).

All controlled substances must be obtained at the same pharmacy, where possible. I understand that my medication(s) will be refilled on a regular basis.

Refill(s) will not be ordered before the scheduled refill date.

Information that I have been receiving medication(s) prescribed by other doctors, that have not been approved previously by Dr. Blissenbach and/or any appropriately authorized assistants may lead to a discontinuation of medication(s) and treatment.

My doctor and/or her appropriately authorized assistant(s) may try alternative medication(s) and/or may taper me off of all narcotic(s). I will not hold my doctor or her appropriately authorized assistant(s), and/or any other member of Dr. Blissenbach's staff liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and blood screens initially as my physician may, in his or her discretion, order. If I test positive for illegal substance(s) at any time, treatment with controlled substances may be terminated and I may be discharged from the care of all physicians at Northeast FL Internal Medicine.

I understand that the State of Florida tracks information provided by pharmacies regarding all controlled substance prescriptions. My physician may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.

I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) as prescribed by Dr. Blissenbach.

Patient Signature	Patient Full Name	Date

Physician (or Appropriately Authorized Assistant) Signature

PATIENT'S ACKNOWLEDGEMENT

I hereby acknowledge that I have been provided with the practice's **NOTICE OF PRIVACY PRACTICES** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name: _____

Patiet Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

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 office.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal and we are committed to maintaining the confidentiality of your medical information. We create and maintain a record of the care and services that you receive in our practice, whether made by your personal doctor or by personnel within our practice.

This notice advises you about the ways in which we may use and disclose medical information about you. It also describes your rights to access and control your medical information. Medical information is about you. Including demographics, that may identify you and relate to your past, present, and/or future physical or mental health condition. This notice also describes your rights and explains obligations we have regarding the use and disclosure of medical information.

WE ARE REQUIRED BY LAW TO:

- Make sure that medical information that identifies you is kept private.
- Provide you with this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms described in this notice.

We may change the terms of this notice at any time. The new notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with any revised **NOTICE OF PRIVACY PRACTICES.**

MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will explain what we mean and provide an example. Not every use or disclosure in a category will be listed below. However, all of the ways which we are permitted to use and disclose information will be included within one of the following categories.

TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, tech, medical students, or other practice personnel who are involves in your medical care treatment. For example, a doctor treating you for a fracture would need to know if you have diabetes because diabetes may slow down the healing process. If you have other physicians, we may request tests and/or labs performed for coordination of care.

PAYMENT: We may need to disclose medical information about services rendered in order to receive reimbursement from the insurance company.

TREATMENT ALTERNATIVES: We may disclose information about you or recommend possible treatment options or alternatives that may interest you. For example, we may use your information to see if you qualify for patient assistance for medications.

INDIVIDUAL INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also advise your friend or family member if you are in the hospital. We may disclose information about you to an entity assisting in a relief disaster so that your family may be notified about your condition, status, and location.

EMERGENCIES: WE MAY ALSO DISCLOSE INFORMATION IN AN EMERGENCY TREATMENT SITUATION. THE DOCTOR SHALL TRY TO OBTAIN YOUR CONSENT AS SOON AS REASONABLY POSSIBLE, AFTER THE DELIVERY OF TREATMENT.

WE MAY RELEASE INFORMATION TO A CORONOR, MEDICAL EXAMINER, OR FUNERAL DIRECTOR. THIS MAY BE NECESSARY TO IDENTIFY A DECEASED PERSON OR TO DETERMINE A CAUSE OF DEATH.

SOMETIMES WE WILL DISCLOSE YOUR MEDICAL INFORMATION WHEN REQUIRED TO DO SO BY FEDERAL, STATE, OR LOCAL LAW. THE USE AND DISCLOSURE WILL BE MADE IN COMPLIANCE WITH THE LAW AND WILL BE LIMITED TO THE RELEVANT REQUIREMENTS OF THE LAW.

LEGAL PROCEEDINGS: If you are involved in a lawsuit or dispute, we may disclose information in response to a court order.

PUBLIC HEALTH: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability
- To report births or deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify recalls of products they may be using
- To notify a person who may be exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been a victim of abuse or neglect or domestic violence. In this case the disclosures' will be made consistent with requirements of applicable state and federal laws.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

CRIMINAL ACTIVITY: Consistent with applicable state and federal laws, we may disclose your medical information if we believe that the use of disclosure is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person of the public.

MILITARY & VETERANS: If you are a member of the armed forces, we may release medical information about you as requested by military command. We may also disclose information about you to the Department of Veteran Affairs upon your separation or discharge from military services.

WORKER'S COMP: We may release medical information about you to comply with Worker's Comp laws or similar programs. These programs provide benefits for work-related injuries or illnesses.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we retain about you.

RIGHT TO INSPECT & COPY: You have the right to inspect and copy information that may be used to make decisions about your care. Usually this includes medical and billing records and any other records that your doctor and the practice use for making decisions about you. We may deny your request to inspect and copy to certain limited circumstances. Under federal law, you may not inspect or copy 1) Psychotherapy notes; 2) Information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action, or proceeding; 3) Medical information that is subject to law that prohibits access to medical information. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request.

To inspect and copy information that may be used to make decisions about you, you must submit your request in writing to our OFFICE ADMINISTRATOR. If you request a copy of the information, we will charge you a fee as PERMITTED by the state law for the costs of copying, mailing, or other supplies associated with your request.

If for any reason you find that medical information we have about you is incorrect or incomplete, you have the right to request an amendment for as long as the information is maintained by this practice. Your request must be made in writing to our OFFICE ADMINISTRATOR. You must provide a valid reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not a part of the medical information obtained by this practice
- Is not a part of the information that you would be permitted to inspect and copy
- Is accurate and complete

RIGHT TO REQUEST CONFIDECTIAL COMMUNICATIONS: You have the right to request that we communicate with you about medical matters in an alternative way or at an alternative location.

THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST: If your doctor believes that it is in your best interest to permit the use and disclosure of your medical information then your medical information will **not** be restricted. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. With this in mind PLEASE DISCUSS ANY RESTRICTIONS YOU WISH TO REQUEST WITH THE DOCTOR.

YOU HAVE A RIGHT TO REQUEST A PAPER COPY OF THIS NOTICE.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Practice Administrator or secretary of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply, will be made only with your written permission. If you provide 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 no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provide you.

PLEASE COMPLETE BY SIGNING AND DATING THE PATIENTS ACKNOWLEDGEMENT SECTION ON THE FOLLOWING PAGE.