Internal and Family Medicine

Ana M. Sierra De Aragon, MD
Jesmina Shrestha, FNP-C
Jessica Diaz, FNP-C

PATIENT INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Marital Status: ☐Married ☐Single ☐Other **Sex:** ☐Male ☐Female

NAME OF RESPONSIBLE PERSON (IF PATIENT IS A MINOR): _____

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian ☐Black/African American
☐White ☐Hispanic ☐Other Race: _____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refused to Report

Languages: ☐English ☐Spanish ☐Russian ☐Indian (Hindi & Tamil) ☐Other: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone/Message:** _____

Email: _____

Patient's Social Security Number (IF MINOR, THE RESPONSIBLE PARTY'S SSN): _____

Detailed Messages (APPOINTMENTS, CALL BACK, LABS, RESULTS, ETC.) ☐Home ☐Cell Phone

Name of Primary Insurance Company: _____

Group #: _____ **Member ID #:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Secondary Insurance Company (IF APPLICABLE): _____

Group #: _____ **Member ID #:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Do you have a living will? ☐Yes ☐No **Do you have a Power of Attorney?** ☐Yes ☐No

EMERGENCY CONTACTS

Primary Emergency Contact Name: _____

Relationship to Patient: _____ **Phone:** _____

Secondary Emergency Contact Name: _____

Relationship to Patient: _____ **Phone:** _____

How did you hear about Internal and Family Medicine? Who may we thank for your referral?

☐Friend ☐Online ☐Insurance ☐Co-Worker ☐Newspaper ☐Other: _____

I have read and understand the patient policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. I understand that I am responsible for all charges, regardless of insurance coverage. I agree to pay my account in accordance with the standard rates and payment terms of this office.
I authorize Internal and Family Medicine to release medical records to my insurance company for the purpose of billing and/or collection of monetary fees. I authorize to receive text messages to the number(s) provided.

Patient Signature: _____ **Date:** _____

Legal Guardian/Representative Signature (IF MINOR): _____ **Date:** _____

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MEDICAL HISTORY

Patient's Name: _____ **Date of Birth:** _____

Medical History: CHECK ALL THAT APPLY

☐Abnormal Heart Rhythm	☐Fainting/Dizzy Spells	☐Kidney Failure	☐Thyroid Disease
☐Allergies	☐Fatigue	☐Lung Disease	☐Tonsillitis
☐Asthma	☐Gastritis	☐Pleurisy	☐Tuberculosis
☐Arthritis	☐Headache	☐Psychiatric Illness	☐Vessel Disease
☐Cancer	☐Hearing Problems	☐Heart Disease	☐Rheumatic Fever
☐Cholesterol/Triglyceride	☐COPD	☐Hearing Loss	☐Bipolar Disorder
☐Weight Fluctuations	☐Glaucoma	☐Scarlet Fever	
☐Disorder	☐High/Low Blood Pressure	☐Stomach/GI Disorder	
☐Depression	☐Influenza	☐Strokes	
☐Diabetes	☐Injuries	☐Other: _____	

Does or did anyone in your family have any of the following from the above list? If so, please list below:

_____

List age or age at death AND specific illness each has, had or cause of death.

Mother: _____ _____

Father: _____ _____

Sibling(s): _____ _____

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? IF YES, PLEASE SPECIFY:

_____ _____ _____

_____ _____ _____

PHARMACY NAME: _____

Address: _____ Phone Number: _____

CURRENT MEDICATIONS:

Type: _____ MG/Dosage: _____ Times Per Day: _____

Type: _____ MG/Dosage: _____ Times Per Day: _____

Type: _____ MG/Dosage: _____ Times Per Day: _____

Type: _____ MG/Dosage: _____ Times Per Day: _____

Type: _____ MG/Dosage: _____ Times Per Day: _____

SURGICAL HISTORY: LIST DATE AND TYPE OF SURGERY

_____ _____

_____ _____

_____ _____

Patient Signature: _____ Date: _____

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SOCIAL HISTORY

What is your current profession? _____

Have you had any of the following? CHECK ALL THAT APPLY

☐Alcoholism ☐Drug Addiction/Dependency ☐Transfusions ☐Sexually Transmitted Disease (STD)

Do you smoke? ☐Yes ☐No **If yes, how much per day?** _____ **Did you smoke in the past?** ☐Yes ☐No

If you quit, when? _____ **How much per day?** _____ **Number of Years:** _____

Do you consume alcohol? ☐Yes ☐No **Type?:** _____ **Number of Glasses:** _____

Do you exercise? ☐Yes ☐No **If yes, how many times per week?** _____

Do you consume caffeine?: (coffee, tea, soda, etc.) ☐Yes ☐No **How Many Cups?** _____

HEALTH CARE MAINTENANCE

LAST DATE OF:

Flu Shot: _____ **Pneumonia Shot:** _____ **DEXA:** _____

Mammo: _____ **Eye Exam:** _____ **Immunization:** _____

NOTICE TO PATIENT

Internal and Family Medicine has a NO NARCOTICS policy.
We will no longer prescribe long term/chronic narcotics and benzodiazepines or other addictive medications to new patients. (i.e. Norco, Vicodin, Xanax, Clonazepam, etc.)
Internal and Family Medicine DOES NOT write letters for emotional support animals.
Patients who are seeking a letter for emotional support animals will be referred to psychiatry/psychology.

Our practice is proud to provide outstanding patient services.
Due to every insurance plan being different, we understand it is part of the patient's responsibility to be aware of what the deductible and/or co-insurance is based on the plan the patient is signed up with.
As a courtesy, we will bill your insurance and send a statement for any remaining balance or out of pocket expenses due from the payment.
Prompt payment is appreciated upon receipt of a statement for any outstanding balance to avoid past due balances.

By signing below the patient or guarantor agrees to pay any deductibles and/or co-insurance for services rendered.

I acknowledge that I have read and understand the above content.

Patient Signature: _____ **Date:** _____

Legal Guardian/Representative Signature (IF MINOR): _____ **Date:** _____

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PRIVACY PRACTICE

I have been informed of how my protected information can be accessed, used and disclosed and I understand that a copy of this policy is available if requested.

I understand that if I want anyone other than those designated by law to have access to these records, I may indicate who below:

NAME	RELATIONSHIP	PHONE NUMBER

Patient Signature: _____ Date: _____

Legal Guardian/Representative Signature (IF MINOR): _____ Date: _____

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Ana M. Sierra De Aragon, MD | Jesmina Shrestha, FNP-C | Jessica Diaz, FNP-C
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AUTHORIZATION FOR RELEASE AND CONSENT FOR DISCLOSURE OF MEDICAL RECORDS

Patient's Name: _____ **Date of Birth:** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate/Contact Phone: _____

PLEASE CHOOSE ONE:

_____ I hereby authorize Internal and Family Medicine to **RECEIVE** medical records from the provider below.

_____ I hereby authorize Internal and Family Medicine to **SEND** medical records from the provider below.

Physician's Name &/OR Clinic: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

☐All Medical Records ☐Referrals ☐Laboratory Results ☐Progress Notes
☐Emergency Room Visits ☐Substance Use/Abuse Information ☐X-Rays ☐EKG's

I hereby authorize the release of copies of the following medical records and am aware of the potential turnaround window of 72 business hours after any and all applicable fees have been paid. Unless otherwise specified, records will be released in secure electronic document format. For the purpose hereof, "medical records" shall include all: I hereby release you, your physician/provider and your employees from any liability for fulfilling the authorization request for release of medical information. This consent is valid for a maximum of one year, or until expressly revoked by me. I may revoke this authorization at any time providing I notify Internal and Family Medicine in writing to that effect. I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original. Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for discloser to a third party. Once this information is released, it may be re-disclosed by the recipient and may no longer by protected information.

Patient Signature: _____ Date: _____
Legal Guardian/Representative Signature (IF MINOR): _____ Date: _____

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FINANCIAL POLICY

This Financial Policy is a critical element in your healthcare arrangements with Internal and Family Medicine. Please, read it carefully as it includes items that you may be charged. Initial only if you agree to be bound by these terms.

I consent Internal and Family Medicine to bill my insurance(s) on my behalf.

It is my responsibility to fully understand my medical insurance policy and to verify all benefits.

It is my responsibility to notify Internal and Family Medicine of ANY changes to my insurance plan or policy prior to my visit; including residence address.

I agree to pay my co-pay/deductible or co-insurance amount prior to each visit.

My insurance company will provide to me and Internal and Family Medicine an EOB (Explanation of Benefits):
I agree to pay what my insurance company states as 'patient responsibility'.
This includes deductibles, co-insurance or uncovered services. Statements are mailed out monthly and are due upon receipt. Additional processing fees will be assessed for each subsequently mailed statement. If after three mailed statements I do not pay my balance in full or agree to a payment plan, Internal and Family Medicine reserves the right to send my account to a collection agency and add 33% to my account balance.

I will be held personally responsible for payment if:
--- I cannot verify that I have insurance at the time of my appointment.
--- I do not have active insurance coverage
- Please ask about our *Cash Pay* policy.

--- My insurance is not contracted with Internal and Family Medicine.
--- I receive a service that is not covered by my policy
--- My insurance company denies my claim for any reason that is not resolvable.

I agree to pay a fee:
--- $50 if my personal check bounces.
--- $50 for SAME DAY CANCELLATION of appointments.
--- $50 for NO CALL NO SHOW to an appointment.
- To avoid a fee, I must cancel Monday to Friday & 24 hours prior to visit.

--- Patients with frequent NO SHOWS may be discharged.
--- 20% fee will be charged to any past due balances over 60 days past due.

Delinquent Balance over 60 days:
No future appointments can be scheduled until the balance is paid in full or payment arrangements are made.

Patient Signature: _____ Date: _____
Legal Guardian/Representative Signature (IF MINOR): _____ Date: _____

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PATIENT POLICY

We request your collaboration and comprehension to make this a viable Practice, and to better serve your healthcare needs in a timely and effective manner.

1. **Referrals to Specialist:**
   - If your Insurance Company requires pre-authorization and special handling:
     - It may take us up to 10 business days to complete their process.
     - We will provide up to two of such Referrals per visit.
     - Medical Assistant will contact you when your Referral is completed.

2. Prepare for your appointment by having questions written down, list of medications you are taking, your insurance card and identification available.
   - Not all health issues may be evaluated during a single appointment; as such, follow up visits may be required.

3. Processing Refills may take up to 1 week. **Please, plan accordingly.**
   - Request them during your visit; otherwise, a new appointment is required.

4. **If you are discharged from a Hospital, you must visit us during the first 3 to 7 days of discharge. You should NOT wait a long period of time before visiting us.**

5. NO-SHOW for an appointment:
   - Patients with frequent NO-SHOW's may be discharged from the Practice.
   - A NO-SHOW fee of $50.00 will be charged to the Patient.

6. CANCELLATION of appointments:
   - Cancellations must be made at least one business day in advance.
   - Same day or late cancellations will incur a fee of $50.00.
   - Patients with frequent late cancellations may be discharged from the Practice.

7. Discharge
   - Patients who do not follow Doctor's instructions or do not comply with medications may be discharged from Practice.
   - Patients on controlled medications will be tested as frequent as necessary.
   - Aggressive Patients who exhibit disrespect to Staff or Doctor will be discharged.

8. For feedback, complaints, comments, suggestions for improvements, request for clarification or waivers on this policy:
   - You can talk directly to the Doctor. You will need to wait until she is available.
   - Email: Feedback@InternalAndFamilyMedicine.com

Patient Signature: _____ Date: _____

Legal Guardian/Representative Signature (IF MINOR): _____ Date: _____

HIPAA 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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information This medical practice collects health information about you and stores it in a chart and in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of this business

Associates that contain terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written

authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made
to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or
Safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach.
22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of
HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.
B. When This Medical Practice May Not Use or Disclose Your Health Information Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. You're Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice

Has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices'. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint as follows: The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Patient Signature: _____ Date: _____

Legal Guardian/Representative Signature (IF MINOR): _____ Date: _____