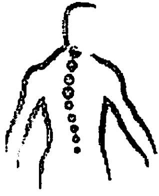


Thank you for choosing Brain and Spine Center

We shall do our best to provide you with quality and courteous care of your neurological needs.

General Consent for Care & Treatment/consentimiento general para el cuidado y tratamiento

You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point, no specific treatment plan has been recommended. This consent form is simply to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any conditions.

This consent provides us with permission to perform reasonable & necessary medical examinations, testing, and treatment. By signing you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or another office under common ownership. The consent will remain effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered. If you have any concerns regarding any test or treatment recommended, we encourage you to ask questions.

Este consentimiento nos da permiso para realizar exámenes médicos, pruebas y tratamientos razonables y necesarios. Al firmar, usted está indicando que tiene la intención de que este consentimiento continúa en la naturaleza, incluso después de un diagnóstico específico se ha hecho y el tratamiento recomendado; Y usted consiente al tratamiento en esta oficina u otra oficina cualquier momento a suspender los servicios y los beneficios de cualquier prueba ordenada. Si tiene alguna preocupación con respecto a cualquier prueba o tratamiento recomendado, le recomendamos que haga preguntas

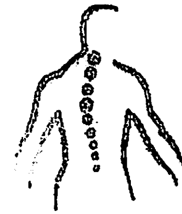
I voluntarily request a physician, mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), other healthcare providers, designees as a necessary, to perform reasonable and necessary medical examination, testing, treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures.

Solicito voluntariamente a un médico, proveedor de nivel medio (Nurse Practitioner, Physician Assistant, o Clinical Nurse Specialist), otros proveedores de atención médica, designados según sea necesario, para realizar un examen médico razonable y necesario, el tratamiento para la condición que me ha llevado a buscar atención en esta práctica. Entiendo que sí se recomiendan pruebas adicionales, procedimientos invasivos o intervencionistas, se me pedirá que lea y firme formularios de consentimiento adicionales antes de las o procedimientos.

*I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.
*Certifico que he leído y entiendo completamente las declaraciones anteriores y doy mi consentimiento completo y voluntariamente a sus contenido.

Signature of Patient or Representative	Patient Name	Date

Patient Questionnaire



Today's Date ____________________

Name:______________________________Age:________

Date of Birth:____________________ M / F SS#____________________

Phone:____________________ Alternate Number:____________________

EMAIL ID: ____________________________ Marital Status: M__ S__ D__ W__

Race: White [ ] African American [ ] American Indian [ ] Other [ ] Decline to Specify [ ]

Ethnicity: Hispanic/Latino [ ] Not Hispanic/Latino [ ] Other [ ] Decline to Specify [ ]

Emergency Contact: ________________Relationship:___________ Phone:___________

Primary Doctor:____________________________ Phone:________________

Patient Employer: __________________________ Phone: ________________

Primary Insurance:____________ ID: _______________________ Group: ____________

Policy Holder:____________________ DOB: ________________ SS#: ______________

Relationship to Patient: Self [ ] Spouse [ ] Other [ ] Policy Holder Employer: __________

Secondary Insurance:____________ ID: ____________________Group: ____________

Policy Holder:____________________ DOB: ________________ SS#: ______________

Relationship to Patient: Self [ ] Spouse [ ] Other [ ] Policy Holder Employer: __________

Reason for Today's Visit: ____

Is this a work-related injury? Yes / No

If you are here for spinal issues, have you had the following for those issued (check all that apply)?

- ☐ Physical Therapy - If yes, when and how long ___________________________
- ☐ Spinal Injections - If yes, when and how many? __________________________
- ☐ Chiropractor - If yes, when and how long? ______________________________
- ☐ Pain Medicine – If yes, when, Buy Whom and How Long?_______________

____

Medication List

Please list your medications and dosages (include vitamins/supplements)

Medication Name	Strength	How Many Capsules	Times per Day

IF YOU HAVE ADDITIONAL MEDS LIST THEM ON THE BACK OF THIS PAGE

Pharmacy Name______________________ Pharmacy Phone No.________________

Pharmacy Address___________________________

Allergies

Allergies to Medication: Are you Allergic to Latex? Yes / No

Medical History

Have you had or do you currently have any of the following medical issues (check all that apply)

	YOU	MOM	DAD	SIBLINGS
Diabetes	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]
COPD	[ ]	[ ]	[ ]	[ ]
Tremors	[ ]	[ ]	[ ]	[ ]
Autoimmune Disease	[ ]	[ ]	[ ]	[ ]
Bleeding Problems	[ ]	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	[ ]
Serious Head Injury	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]
Stomach Ulcers	[ ]	[ ]	[ ]	[ ]
Aneurysm	[ ]	[ ]	[ ]	[ ]
Hepatitis	[ ]	[ ]	[ ]	[ ]
Thyroid	[ ]	[ ]	[ ]	[ ]
HIV/AIDS	[ ]	[ ]	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]	[ ]	[ ]
Parkinson's	[ ]	[ ]	[ ]	[ ]
Back/Neck Injury	[ ]	[ ]	[ ]	[ ]
Cancer: Type__________	[ ]	[ ]	[ ]	[ ]

Please List Any other Medical Problems: ____________________

____

____

How is the pain effecting you daily living? ____________________

What makes pain better or worse? ____________________

What aggravates the symptoms? ____________________

Location of Pain? ____________________

Severity of Pain on a 1-10 scale? _______

Duration of Pain? ____________________

Is Pain? Shooting [ ]

Stabbing [ ] Numbing [ ]

Tingling [ ] Sharp [ ] Popping [ ]

Mark and X where

Pain is located

Social History

Have you ever smoked? Yes / No
Please fill in the chart below

	Present	Past	Age at Start	How many per da
Tobacco (Smocking, Chewing)	Yes / No	Yes / No		
Alcohol	Yes / No	Yes / No		
Other Substances (Marijuana, Cocaine, heroin, etc)	Yes / No	Yes / No		
Caffeinated Foods (tea, chocolate, coffee)	Yes / No	Yes / No		

Surgical History:

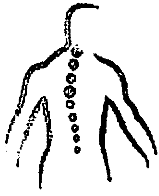
Procedure	Date of Procedure

If you have additional surgeries please list them on the back of this page

Have you been feeling ANY of the following symptoms (check all that apply)?

❑ Chills ❑ Fevers ❑ Weight Change ❑ Blood Transfusion ❑ Swallowing	❑ Escalofrios ❑ Fiebres ❑ Cambio de Peso ❑ Transfusión de sangre ❑ Tragar	❑ Loss of Consciousness ❑ Dizziness ❑ Memory Loss ❑ Hearing Loss ❑ Sleeping Problems	❑ Pérdida de conc ❑ Mareos ❑ Pérdida de men ❑ pérdida auditiva ❑ Problemas para dormir
❑ Double Visioned ❑ Blurred Vision ❑ Loss Of Vision	❑ Doble visión ❑ Visión borrosa ❑ Pérdida de visión	❑ Excessive thirst ❑ Feel too Cold Frequently ❑ Feel too hot frequently	❑ Sed excesiva ❑ Sentirse demas frío con frecuen ❑ Siéntase demas caliente con frecuencia
❑ Wheezing ❑ Shortness of Breath ❑ Frequent of cough	❑ Sibilancias ❑ Dificultad para respirar ❑ Frecuente de tos	❑ Anemia ❑ Swollen Glands ❑ Bleeding Problems	❑ Anemia ❑ Glándulas hinch ❑ Problemas de sangrado
❑ Chest Pain ❑ Heart Palpitations ❑ Fainting Spells ❑ Depression ❑ Rash	❑ Dolor de pecho ❑ Palpitaciones ❑ Hechizos de desmayos ❑ Depresión ❑ Erupción	❑ Hay Fever ❑ Environmental Allergies ❑ Anaphylaxis	❑ Fiebre del heno ❑ Alergias Ambier ❑ Anafilasis
❑ Back Pains ❑ Joint Pains ❑ Neck Pains ❑ Shooting Arm Pain ❑ Shooting Leg Pain	❑ Dolores de espalda ❑ Dolores articulares ❑ Dolores de cuello ❑ Dolor de brazo de tiro ❑ Dolor de pierna de tiro	❑ Increased Urinary Frequency ❑ Painful Urination ❑ Urinary Retention	❑ Aumento de la frecuencia urina ❑ Urina dolorosa ❑ Urinary Retentic ❑

HIPAA Release of Information



HIPAA dictates that our office must do everything possible to protect your medical information. For this reason please indicate below who we may leave messages with or talk to regarding appointments, prescriptions, test results, surgery, dates and any other medical need we may have. Please list the phone number below where you can most likely be reached during our business day.

HIPAA dicta que nuestra oficina debe hacer todo lo posible para proteger su información médica. Por esta razón, indique a continuación que podemos dejar mensajes o hablar con acerca de citas, recetas, resultados de exámenes, fechas de cirugía, y cualquier otra necesidad médica que tengamos. Por favor, indique el número de teléfono a continuación, donde es muy probable que pueda encontrar durante nuestro día hábil.

Phone #:______________________________

Is it OK to leave a message?_______yes ________no ?Está bien dejar un mensaje? ________si ________no

I will allow medical information and test results including abnormal results and appointment information to be released to the following people:

Voy a permitir que la información médica y los resultados de las pruebas, incluyendo los resultados anormales e información cita para ser relased a las siguientes personas:

Name/Nombre	Relationship/Relación	Phone/Telefono

* _______ I DO NOT want medical information, test results released to anyone BUT myself. This form will be valid until revoked by me in writing

*_______ NO quieren la información médica, resultados de la pruebas, dado a conocer a nadie más que a mí mismo, Este formulario será válida hasta sea revocada por mí por escrito

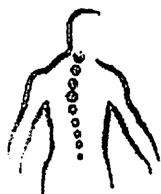
HIPAA Acknowledgement Form

I hereby acknowledge by signature below that I have been given a copy of the HIPAA Privacy Policy for review. I also acknowledge that I have read and been given an opportunity to ask any questions related to my privacy rights. This form is to be retained in my medical chart until revoked by me in writing

Por la presente acuso por debajo de la firma que se me ha dado una copia de la Política de Privacidad de HIPAA para su revisión. También reconozco que he leído y dado la oportunidad de formular todas las preguntas relacionadas con mis derechos de privacidad. Este formulario debe ser retenido en mi expediente médico hasta que sea revocado por mí por escrito.

Patient Name/Su Nombre:________________________________ Date/Fecha:____________________

Prescription Policy



It is the policy of Brain & Spine Center to deliver quality care and treatment to all of our patients. Taking into account the nature of our specialty we realize that many patients come to us with chronic pain or some level of pain. It is our hope and belief that this pain can be treated conservatively through non-narcotic medication or surgical intervention if required.

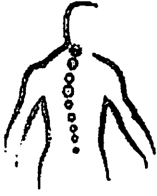
Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are therefore **closely controlled by local, state, and federal governments.** They are intended to relieve pain, thus improving function and/or ability to work. Because the provider is prescribing controlled substance medications to help manage my pain, **I agree to the following conditions:**

1. I am responsible for any controlled substance medications prescribed to me. If my prescription is lost, misplaced, stolen, or if I "run out early" I understand that it will not be replaced.
2. Refills of controlled substance medications:
    a. Will be made only during regular office hours: Monday through Friday.
    b. Will not be made as an emergency," and will require notification at least 24 hours in advance.
3. Triplicate prescription narcotic pain medications will not be administered. IF they are, they will be given in the office.
4. We no longer prescribe SOMA or LORCET.
5. Pain medication will not be provided to those under care of a pain specialist.
6. It may be deemed necessary by the provider that I see a **medication-use specialist** at any time while I am receiving controlled substance, medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction, my medication will no longer be refilled).
7. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance and medications from physicians, medical facilities, and appropriate authorities.
8. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control, and avoidance of tobacco and alcohol.
10. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
11. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies there will be notification.

The pharmacy I use is:____ Ph:____________________________

***I have read this contract and I fully understand that the consequences of violating this agreement may result in my termination as a patient of this practice**

Patient Signature:__________________________________ **Date:**______________________



Disclosure and Authorization Form for Patient Referral to Other Non-participating Physicians or Facilities Advocacy for patient Freedom of Choice for Provider

Patient name:______________________ **Physician Name:** ______________________

Diagnosis:__________________________ ***Physicians:** Erwin Lo, Sujin Yu,

Treatment: __________________________ Arshad Khan, Hassan Chahadeh, Clifton Hancock, Cheryl Sadler

Patient Plan In-Network______________________

In order to better serve you with the highest quality care and safety at the most affordable costs, sometimes it is necessary and important to have other additional providers/entities to join our team to complete or continue your medical procedures or treatment in order to ensure speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other providers/entities and obtain your informed consent before our referral and scheduling for your next procedure. While no provider/entity could be participating in every managed care network, such as the one your health plan has contracted with, these other providers/entities may or may not be in your health plan network. This disclosure and authorization form is used to inform you of our verification that the above name providers/entities are or may be non-participating providers/entities with your health plan.

We have verified your insurance coverage for non-participating providers/entities and the recommended treatment/procedures and obtained pre-certification if applicable for all services as a courtesy to you. Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan. If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider/entities, please call the number services number on your insurance card.

Compliance & Disclosure under Texas Occupations Code-Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor/facility have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of providers/entities/facility: (A) affiliation, if any, with the doctor or facility for whom the patient the patient is referred and (B) that he/she will receive directly or indirectly remuneration for referring upon my such request and exercising my right of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA.

Doctor or Facility with affiliation and remuneration: Erwin Lo, MD, SUJIN YU, MD, Arshad Khan DPM, David Singleton, MD, Baominh Yinh, MD, Hassan Chahadeh, MD, Craig Charleston, Mark Larson, David Singleton MD, Karan Madan, MD, Scott Lin, MD, Pin Oak Medical Center, Katy Pain & Spine, Trinity Pearland Medical Center, Country Palace Medical Centre, Interventional Pain Center, Brain and Spine Center, Woodlands Way Medical Center, I45 Medical Center, League Line Medical Center North Mesa Medical Center, Southwest Texas Medical Center Victory Campus, Steeplechase Medical Center, Northwest Houston Medical Center, Dowlen Center for Pain, Metropolitan Park Medical Center, Victory Medical Center Houston, SpineTECH Surgery Center, True Island Medical Center. Any other physicians contracted by or affiliated with these providers/entities. Any other Physician Owned Entity that may have been referred to by these providers/entities.

*I certify that the advocacy for patient freedom of Choice for providers with the above specific disclosure from my providers is in full compliance with the section 102.006 of Texas Occupations Code, in a manner otherwise permitted under section 102.001, in accepting remuneration to advocate, protect, secure, or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.

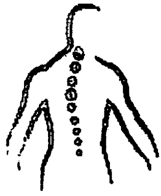
*I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity

*I certify that my attending physician has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving and for the provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan due to out-of-network coverage.

***I have read and fully understand the disclosure and authorization form. I hereby authorize this referral to non-participating and out-of-network providers/entities as named above.**

______________________ ______________________ ______________________

Signature Patient Name Date



Brain & Spine Center of Southeast Texas
Member Advance Notice Form for the Involvement of a Non-Participating Provider

Your physician or other health care professional has decided to involve a non-participating physician, facility or other health care provider in your care. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your physician or other health care professional about your option to utilize a participating provider and you have agreed to receive services from a non-participating provider despite potential increased out-of-pocket costs associated with that decision.

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. You may be responsible for the entire cost of the services. If you have questions or would like to find a participating provider you can, however, it is important you understand that you may have higher out-of-pocket costs when using a non-participating provider based on your benefit plan. Please also note that if you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a non-participating provider, you may be responsible for the entire cost of the service. If you have questions or would like to find a participating provider that can perform the services you require, please ask your physician or other health care professional to arrange for the use of a participating provider. You can confirm the participating status of providers by contacting your insurance plan at the telephone number on the back of your health plan ID card. You may also log onto most insurance websites to search on the online provider directory for a participating provider in your area.

To be completed by the number's physician or other health care professional:

Physician/Health Care Professional Name: **Erwin Lo, Sujin Yu, Cheryl Salder, Clifton Hancock, Hassan Chahadeh, Arshad Khan**

Physician/Health Care Professional Tax ID #: **463246561**

Member Name:____

Member ID #:____

Non-Participating Physician/Facility/Healthcare provider name: SpineTECH Surgery Center, Dowlen Center for Pain

Type of Service Non-Participating Provider will Render: EMG, Pain Management Injection, SCS Trial/Implant, Surgery

Reason for Involving Non-Participating Provider: Proximity, provider reputation, patient convenience, quality of care

To be Completed by the member of the member/s legal guardian:

I am aware that the physician, facility or other health care provider listed above will be involved in my care of the date of service listed above and I understand that this health care provider is not a participating provider in my insurance network. I was provided and declined the opportunity to select a participating provider to provide the health care services indicated above and a voluntarily choosing to obtain services from a non-participating provider. I am aware that I may be responsible for any additional costs resulting from my use of a non-participating provider, if I provide in my benefit plan. I understand that non-participating providers are generally prohibited from waiving member cost share amounts such as copayments, deductibles and coinsurance.

____

Signature of Member, Parent (if the member is under age 18) or Legal Guardian

____

Printed Name of Member, parent (if the member is under age 18) or Legal Guardian

____

Date Telephone Number

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Brain & Spine Center of Southeast Texas
111 Vision Park BLVD Suite 245
Shenandoah,Texas 77384
Phone : 936-647-0202
Fax: 888-965-6807
Hassan Chahadeh, MD

Erwin Lo MD, Neurosurgeon
Sujin Yu MD, Neurologist
Clifton Hancock MD, Orthopedic Surgeon
Cheryl Sadler, NP
Arshad Khan, Podiatrist

Patient's Name:
SS# (last 4 #s)
I request & authorize Brain & Spine Center to release medical record/healthcare information to
Name:
Phone:
Fax:

This request and authorization applies to:

________ All Healthcare records/information

________ Healthcare information relating to continuing care for the following treatment, condition or DATES OF SERVICE:____ Other:

I authorize the following healthcare professional, medical facility, mental health facility, laboratory, medical records service, pharmacy, clearinghouse, insurance payer, disability determination, employer, or family member to release all health information about me

TO BRAIN & SPINE OF SOUTHEAST TEXAS:

Person or Organization to release information:
Name:
Phone:
Fax:

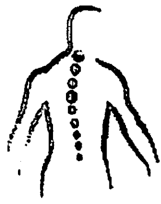
---

*Authorization is not required as defined by HIPAA and Texas Health and Safety code 181.001 for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law for continuing care or emergency purposes. Entire medical record includes patient histories, office notes, test/lab results, referrals, radiology studies/films, consults, authorizations, insurance records, letter of protection, prescription records, and records sent by other providers. This information can be obtained for the purposes of continuing care, diagnostic or therapeutic purposes, testing, counseling, and prescribing medications. Health information may be used or disclosed pursuant to this authorization and may be subject to re-disclosure by the recipient any may no longer be protected by law. This authorization is valid as the original. I am entitled to a copy of this authorization. I have read this authorization and agree to its terms as indicated by signature below:

______________________ Patient Signature

______________________ Patient Name

______________________ Date



NOTICE OF PRIVACY PRACTICES: Patient Copy: 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.

You have the right to: Get a copy of your paper or electronic medical record. Correct your paper or electronic medical record. Request confidential communication. Ask us to limit the information we share. Get a list of those with whom we've shared your information. Get a copy of this privacy notice. Choose someone to act for you. File a complaint if you believe your privacy rights have been violated. **You have some choices in the way that we use and share information as we:** Tell family and friends about your condition. Provide disaster relief. Include you in a hospital directory. Provide mental health care. Market our services and sell your information. Raise funds. **We may use and share your information as we:** Treat you. Run our organization. Bill for your services. Help with public health and safety issues. Do research. Comply with the law. Respond to organ and tissue donation requests. Work with a medical examiner or funeral director. Address workers' compensation, law enforcement, and other government requests. Respond to lawsuits and legal actions. **We are required by law to maintain the privacy and security of your protected health information.** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time. Let us know in writing if you change your mind.

This section explains your rights and some of our responsibilities to help you: Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. **Ask us to correct your medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. We may decline your request, but we'll tell you why in writing within 60 days. **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. **Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment out operations with your health insurance. We will say "yes" unless a law requires us to share that information. **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. **Get a copy of this privacy notice:** You can ask for a paper copy of this notice any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. If you have some medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W.,Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hh.gov/ocr/privacy/hipaa/complaints.** We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. **In these cases. You have both the right and choice to tell us to:** Share information with your family, friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* **In these cases, we never share your information unless you give us written permission:** marketing purposes. In the case of fundraising: we may contact you for fundraising efforts, but you can tell us not to contact you again. **We typically use or share your health information in the following ways:** We can use your health information and share it with other professionals who are treating you. We can use and share health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities. We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We can share health information about you for certain situations such as: preventing disease. Helping with product recalls. Reporting adverse reactions to medications. Reporting suspect abuse, neglect, or domestic violence. Preventing or reducing a serious threat to anyone's health or safety. We can use or share your information for health research. We will share information about you if state or federal privacy law. We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual die. For authorized by law. For government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order, or in a response to a subpoena. For more information:
www.hhs.gov/ocr/privacy/hippa.understanding.consumers/index.html. **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.**