ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

PATIENT REGISTRATION

Patient First Name: _____ MI: _____ Last: _____ Suffix: _____

Preferred Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____

Zipcode: _____ Home Phone: _____ Cell Phone: _____

What was your sex assigned at birth? ☐ Female ☐ Male

What is your gender identity? ☐ Female ☐ Male ☐ Non-Binary

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

Race: (Check all that apply) ☐ White ☐ African America ☐ American Indian/Alaskan Native ☐ Asian

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Decline to answer

Preferred Language: ☐ English Other _____ ☐ Decline

Residence Status: ☐ Alone ☐ with Family ☐ Nursing Home ☐ Seasonal Resident ☐ Homeless / No Permanent address

May we leave a message on your answering machine/voicemail?

☐ Yes ☐ No

May we send text messages to your cell phone?

☐ Yes ☐ No

What is your preferred method of contact?

☐ Phone Call ☐ Text Message ☐ Email

Email Address: _____

Do you have advanced directives (Healthcare Power of Attorney, Living Will, Do Not Resuscitate Order)

☐ Yes ☐ No If yes, please bring a copy for our records.

EMPLOYMENT STATUS

☐ Employed/Self Employed ☐ Unemployed ☐ Disabled ☐ Retired from:

Occupation: _____

Name of Employer: _____

Employer Address: _____

Work Phone: _____

Marital Status ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Spouse First Name: _____ MI: _____ Last: _____ Suffix: _____

DOB: _____ Age: _____

Spouse Address: _____

City: _____ State: _____ Zip: _____

Spouse Employer: _____

Spouse Work Phone: _____ Retired? ☐ Yes ☐ No

Spouse Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Contact: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Primary Insurance: _____ Subscriber: _____

Relationship to patient: _____ Name: _____

Subscriber Employer: _____ Phone: _____

Subscriber ID # _____ Subscriber DOB: _____

Group # _____

Secondary Insurance: _____ Subscriber: _____

Relationship to patient: _____ Name: _____

Subscriber Employer: _____ Phone: _____

Subscriber ID # _____ Subscriber DOB: _____

Group # _____

Prescription Coverage: _____ Part D: _____

Other: _____ ID# _____

MEDICAL HISTORY Check the items that apply to you (current or history)

- ☐ None
- ☐ Asthma
- ☐ Chronic Lung (COPD)
- ☐ Emphysema
- ☐ Pneumonia/Bronchitis
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)

- ☐ Cirrhosis of Liver
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Gallstones
- ☐ GERD/Heartburn
- ☐ Hepatitis A/B/C
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis

- ☐ Enlarged prostate
- ☐ Freq. Urinary Tract Infections
- ☐ Kidney Disease/Failure
- ☐ Kidney stone

- ☐ Lupus-Autoimmune
- ☐ Reynaud's Syndrome
- ☐ Rheumatoid Arthritis

- ☐ Chronic back pain
- ☐ Fracture
- ☐ Joint Replacement
- ☐ Osteoarthritis
- ☐ Osteoporosis

- ☐ Migraines
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Shingles

- ☐ Glaucoma/Cataracts
- ☐ Hearing Loss
- ☐ Vision Loss

- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple Myeloma

- ☐ Anxiety
- ☐ Mood Disorder
- ☐ Problems with Anesthesia

- ☐ Diabetes
- ☐ Thyroid Disease

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Attack – MI
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Multiple sclerosis
- ☐ Peripheral Vascular Disease
- ☐ Rheumatic Fever
- ☐ Stroke

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Clotting Disorder
- ☐ Frequent Infections

- ☐ Anxiety
- ☐ Depression
- ☐ Drug Use
- ☐ HIV
- ☐ Mood Disorder

Other Medical History: _____

_____

_____

Cancer History: _____

Date diagnoses: _____

Type: _____

Treatment (type, date, and location of treatment): _____

PAST SURGICAL HISTORY (Please circle and date any of the surgeries and/or procedures that you have undergone)

Coronary Stent	Date: _____	Lung Surgery	Date: _____
Angioplasty	Date: _____	Cataract	Date: _____
Pacemaker	Date: _____	Gallbladder Surgery	Date: _____
Cardiac Valve Surgery	Date: _____	Appendectomy	Date: _____
Colon Surgery	Date: _____	Prostatectomy	Date: _____
Mastectomy	Date: _____	Hysterectomy	Date: _____
Lumpectomy	Date: _____		

Other Operations: _____

Findings: _____

HEALTH MAINTENANCE

Last Mammogram	Date: _____	Influenza (Flu) Shot	Date: _____
Last Bone Density	Date: _____	Pneumococcal Shot	Date: _____
Last Pelvic Exam	Date: _____	Last Shingles Shot	Date: _____
Last Colonoscopy	Date: _____	EGD	Date: _____
Last Prostate Exam	Date: _____	Endoscopy	Date: _____

FEMALES ONLY

Last Menstrual Period: _____ First Period (Age): _____

Hysterectomy: Yes / No: Date: _____ Prior/Current use of Oral Contraceptives _____

Number of Pregnancies: ___ Number of Miscarriages: ___ Prior/Current use of Hormones _____

Number of Live Children: ___

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Please list any additional Physicians you have seen (include phone #):

Surgeon: _____ Phone: _____

Radiation Oncologist: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment. (if additional space is needed use reverse side)

Medication	Strength	Dose	How many times a day

ALLERGIES

☐ No Known Drug Allergies

Medication (Include prescription, over-the-counter, and/or vitamins)	Describe Reaction

Have you ever had an allergic reaction to:

☐ CT/IV Contrast ☐ Shell Fish ☐ Latex

What type of reaction did you have: _____

Additional Comments and/or Information: _____

PHARMACY INFORMATION

☐ **Illinois CancerCare Retail Pharmacy** (Offering Online Refills Requests and Complimentary Home Delivery via Courier)

Pharmacy Name _____ **Phone Number** _____

Address _____

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

SOCIAL HISTORY:

TOBACCO USE: (Present and/or Past) ☐ Never Smoked ☐ Quit smoking: When? _____

How many years did you smoke? _____ yr(s) How many packs? _____ / day

Currently Smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ E-Cigs / Vape ☐ Chewing Tobacco

How many packs? _____ / day How many years? _____ yr(s)

If eligible, would you be interested in discussing lung cancer screening with your provider? YES / NO

If no, do you already receive lung cancer screening? YES / NO

RECREATIONAL/STREET DRUGS:

☐ Marijuana _____ per ☐ Day ☐ Week ☐ Month ☐ Medicinal Certifying Physician _____

☐ Recreational Other _____

ALCOHOL HISTORY: (Present and/or Past) ☐ Non Drinker

How many years have you been drinking? _____

How long since you have quit drinking? _____

FAMILY HEALTH HISTORY:

	If Living Age/Health	If Deceased Age/Cause of Death
Father:		
Mother:		
Brother or Sisters:		

	If Living Age/Health	If Deceased Age/Cause of Death
Partner:		
Son or Daughters:		

Has anyone in your family been diagnosed with any type of cancer? YES / NO

If yes, which cancers? _____

Have you or any of your family members had colon polyps? YES / NO How many? _____

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Patient First Name: _____ DOB: _____

Todays Date: _____

Review of Symptoms: (Please check any CURRENT symptoms you have).

General:
- ☐ Pain 0 - 10 ____
- ☐ Weight loss ____lbs ____time
- ☐ Weight gain ____lbs ____time
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue

Eyes:
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred Vision
- ☐ Double Vision

Ears, Nose, Throat:
- ☐ Hard of Hearing or Deaf
- ☐ Ringing in Ears
- ☐ Enlarged Lymph nodes
- ☐ Chronic Sinus Problems
- ☐ Sore Throat
- ☐ Mouth Pain/Sores

Changes/Difficulty In:
- ☐ Taste
- ☐ Smell

Cardiovascular:
- ☐ Chest Pain/Angina Pectoris
- ☐ Palpitations/Heart Murmur
- ☐ High/Low Blood Pressure

Respiratory:
- ☐ Chronic or Frequent Cough
- ☐ Bloody Sputum
- ☐ Shortness of Breath

Physical Problems
- ☐ Appearance
- ☐ Bathing/Dressing
- ☐ Getting Around

Skin:
- ☐ Rashes or Itching
- ☐ Change in Skin Color or Moles
- ☐ Varicose Veins
- ☐ Skin Cancer

Allergies/Immunology:
- ☐ History of Allergies
- ☐ Chronic Infections

Gastrointestinal:
- ☐ Difficult or Painful Swallowing
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Heartburn/Indigestion/Belching
- ☐ Lump/Sensation in Throat/Food Sticking
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Black or Tarry Stool
- ☐ Excessive Rectal Gas/Flatus
- ☐ Loss of Stool/Fecal Accident
- ☐ Poor Appetite
- ☐ Jaundice

Genitourinary:
- ☐ Kidney Stones
- ☐ Pelvic Pain
- ☐ Incontinence
- ☐ Burning or Pain on Urination
- ☐ Blood in Urine
- ☐ Difficult Urination
- ☐ Men: Prostate Problems
- ☐ Testicular Issues
- ☐ Erectile Dysfunction

Breast:
- ☐ Rashes or Itching
- ☐ Changing in Skin Color
- ☐ Varicose Veins
- ☐ Skin Cancer
- ☐ Breast Pain/Lump
- ☐ Breast Discharge

Musculoskeletal:
- ☐ Joint Pain/Arthritis
- ☐ Muscle or Joint Weakness
- ☐ Bone Pain
- ☐ Muscle Aches

Neurological:
- ☐ Numbness/Tingling
- ☐ Arm or Leg Weakness
- ☐ Light-Headed/Dizzy/Fainting spells
- ☐ Tremors/Headaches

Hematologic:
- ☐ Easy Bruising
- ☐ Gum or Nose Bleeding
- ☐ Blood Transfusions

Endocrine:
- ☐ Heat or Cold Intolerance
- ☐ Excessive Skin Dryness
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Weight Problem
- ☐ Libido
- ☐ Hot Flashes
- ☐ Vaginal Dryness

Psychiatric:
- ☐ Anxiety/Agitation/Worry
- ☐ Depression/Sadness
- ☐ Crying for No Reason
- ☐ Insomnia
- ☐ Alcoholism
- ☐ Drug Problem
- ☐ Loss of Interest in Usual Activities

Spiritual/Religion:
- ☐ Spiritual Concerns

Emotional Wellbeing Distress Management

Practical Problems:
- ☐ Child Care
- ☐ Housing
- ☐ Insurance/Financial
- ☐ Transportation
- ☐ Work/School
- ☐ Treatment Decisions

Family Problems:
- ☐ Dealing with Children
- ☐ Dealing with partner
- ☐ Ability to have Children
- ☐ Family Health Issues

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

ASSIGNMENT OF INTEREST AND FINANCIAL AGREEMENT

FINANCIAL AGREEMENT. In consideration of the services to be rendered to Patient, Patient individually promises to pay the Patient's account at Illinois CancerCare at the charged rates as reduced by any applicable third-party contract.

RELEASE OF INFORMATION FOR BILLING. Patient authorizes release to insurance companies or their administering entities, governmental agencies or their intermediaries, and third party payors providing benefits to Patient, copies of all medical records or other information necessary to determine available benefits and to obtain payment for the service rendered to Patient by Illinois CancerCare. Patient understands that: (a) Patient's medical records may contain information relating to mental health, developmental disabilities, alcohol and/or drug abuse diagnosis and/or treatment, HIV/Aids test results and genetic information, and Patient authorizes release of such medical records for purposes of billing and collection; (b) Patient has the right to inspect and to obtain a copy of the information disclosed; (c) this authorization is valid with respect to mental health records until the date one year following today's date; (d) Patient has the right to revoke this authorization at any time, except to the extent that actions were taken in reliance thereon; and (e) if Patient refuses to sign or revoke this authorization, Illinois CancerCare may not be able to release medical information which is necessary to process claims for insurance benefits and Patient will be billed directly for these services.

ASSIGNMENT OF BENEFITS. Patient hereby irrevocably assigns to Illinois CancerCare any and all rights which the undersigned and Patient have against any insurance companies or their administering agencies, government agencies or their intermediaries, or other third party payor for payment of the Patient's bill to Illinois CancerCare. The Patient authorizes the application of any overpayment to any unpaid bill at Illinois CancerCare for which the Patient is responsible that has not been paid in full at the time of the overpayment.

FOR MEDICARE/MEDICAID BENEFICIARIES ONLY. Patient ce1tifies that the information given by Patient in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. Patient requests that payment of authorized benefits be made on Patient's behalf for any services furnished Patient by Illinois CancerCare. Patient authorizes any holder of medical or other information about Patient to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information necessary to determine these benefits or related services.

Patient: _____ **Date:** _____
Please print full name

Signature: _____

Date of Birth: _____

If signed by an authorized representative of the Patient, please indicate relationship to Patient (e.g. spouse):

Relationship: _____ **Witnessed by:** _____

This authorization shall be in force until revoked by me in writing or a new one is signed, a photocopy of this authorization shall be as valid as the original.

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

HIPAA RIGHT OF ACCESS
AUTHORIZATION FOR FAMILY/FRIEND

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

I hereby authorize Illinois CancerCare, P.C. ("ILCC") to release to the following individual(s):

NAME	RELATIONSHIP	PHONE NUMBER

all medical related information contained in my patient record, excluding any information not initialed below, at my request and for the purpose of assisting me with my treatment at ILCC. If you have **NOT** listed a person on this form our staff **WILL NOT DISCUSS ANY INFORMATION** with that person either by phone or in person.

By initialing any of the lines below, I am specifically authorizing ILCC to use and/or disclose the category of confidential Information indicated next to the line, if applicable to this authorization.

_____ Genetic Testing (ex: BRCA, PTEN, MSH2, etc)
_____ Drug Abuse Treatment Records
_____ HIV/Acquired Immune Deficiency Syndrome
_____ Alcoholism Treatment Records
_____ Mental Health Treatment Records

NOTICE

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that ILCC may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to ILCC of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where ILCC has already relied on it to use or disclose my health information. Written revocation must be sent to ILCC at the following address: **8940 N Wood Sage Rd, Peoria, IL 61615, Attn: Privacy Officer.**

Absent such written revocation, this **Authorization for Release of Confidential Heath Information** will terminate at the termination of my patient relationship with ILCC.

Signed: _____ **Dated:** _____

If you are not the patient, please state the basis for your authority to act on behalf of the patient: _____

Representative Name: _____

Representative Address: _____

Representative Phone / Email: _____

NOTE: This Authorization was revoked on (DATE)_____ Signature Of Staff _____

NOTICE TO RECIPIENT OF PROTECTED HEALTH INFORMATION: No records or information from such records which are within the provisions of (1) the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (2) the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, (3) the Illinois AIDS Confidentiality Act, (4) the Illinois Genetic Confidentiality Act, or (5) other similar laws, may be further disclosed unless the person who executed the Authorization specifically consents, in writing, to such re-disclosure. A general authorization for release of medical or other information is not sufficient for this purpose. 519-6

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

AUTHORIZATION FOR RELEASE
MEDICAL RECORDS

I, _____ , authorize all entities that share in my medical treatment to furnish Illinois CancerCare with all personal health information and medical records, including those related to mental health, developmental disability, substance abuse, HIV/AIDS, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I also authorize Illinois CancerCare to release any personal health information and medical records about me to other health care providers, insurance companies, or other third party payors necessary for Illinois CancerCare to provide treatment, payment, or health care operations related to my care, including those records related to mental health, developmental disability, substance abuse, HIV/AIDs, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I understand that this authorization shall be in force until revoked by me in writing or a new one signed. A photocopy of this authorization shall be as valid as the original. I understand that to revoke this authorization I must provide written notice to Illinois CancerCare, Attention Chief Privacy Officer at 8940 N Wood Sage Rd, Peoria, IL 61615.

Date of Birth: _____ **SS#:** _____

Signature: _____ **Date:** _____

If signed by an authorized representative of the patient, please indicate relationship to patient (e.g. spouse):

Relationship: _____ **Witnessed by:** _____

512-002

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

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

Illinois CancerCare is required to provide you with a copy of its Notice of Privacy Practices. This Notice of Privacy Practices provides information about how Illinois CancerCare may use and disclose your protected information. We encourage you to read it in full. Please sign this form to acknowledge receipt of the Notice.

This Notice of Privacy Practices is subject to change. A copy of the current Notice of Privacy Practices is available at each of our offices. A copy can also be found on our website: www.illinoiscancercare.com.

_____ _____
Signature Of Patient or Personal Representative **Date**

_____ _____
Name of Patient/Patient Representative (please print) **Relationship to Patient**

FOR ILLINOIS CANCERCARE USE ONLY
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM THE PATIENT

On _____, I made a good faith effort to obtain written acknowledgement of receipt of our Privacy Practices, but

☐ **Patient/Representative Declined to Sign**

☐ **Emergency Situation Prevented Acknowledgement**

☐ **Other (Please Specify):** _____

_____

_____

_____ _____
Employee Signature **Date:**

Your RIGHTS

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

Your CHOICES

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

Your USES AND DISCLOSURES

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

Our RESPONSIBILITIES

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. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

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, and on our web site.

Effective Date 05/01/2019

ILLINOIS CANCERCARE, P.C.

Specializing in Cancer and Blood Disorders

FOR MORE INFORMATION

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment and payment purposes. Participation in an electronic health information exchange also lets us see their information about you for our treatment and payment purposes.

Illinois and federal law provide additional protection for certain types of medical information. No records or information from records which are within the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Act of July 1, 1975 (Confidentiality of Alcohol and Drug Abuse Patient Records), the Illinois AIDS Confidentiality Act, or the Illinois Genetic Confidentiality Act may be disclosed unless you specifically consent, in writing, to such disclosure. Illinois law also provides additional protection for individuals when law enforcement officials seek medical information for use in a criminal prosecution. These and other laws may further limit whether and how we may disclose medical information about you to others.

Illinois CancerCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-309-243-3000.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-309-243-3000.

Have a question?

PRIVACY OFFICIAL:

Janelle Hamilton
309-243-3456
jhamilton@illinoiscancercare.com

Your INFORMATION. Your RIGHTS. OUR Responsibilities.

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.

ILLINOIS CANCERCARE, P.C.

Specializing in Cancer and Blood Disorders

Your RIGHTS

When it comes to your health information, you have certain rights.

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.
- Ask us how to do this.
- We may say "no" to 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 or our operations with your health insurer. 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 at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone 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 to the Privacy Official if you feel we have violated your rights by contacting us using the information on the back of this brochure.
- 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.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your CHOICES

For certain health information, you can tell us your choices about what we share.

IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO:

- Share information with your family, close 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
- Sale of your information
- Most sharing of psychotherapy notes

IN THE CASE OF FUNDRAISING:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

- 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. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Our USES AND DISCLOSURES

How do we typically use or share your health information?

TREAT YOU

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

- We can use or share your information for health research.

COMPLY WITH THE LAW

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

- We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.