Advanced Healthcare Center
391 South 1st Street, Jesup GA. 31545

Thank you for allowing Advanced Healthcare Center (AHC) to participate in your healthcare needs. We are here to serve you.

Advanced Healthcare Center (AHC) is a multidisciplinary healthcare facility with multiple Medical, Chiropractic, and Massage Therapy Providers working as a team to formulate a comprehensive Evaluation and Treatment Plan that will restore you to maximum medical improvement as soon as possible.

It is important to understand that Sandra Bohnstengel,MD, is the medical director at AHC and ultimately reviews all patient charts to make sure All medically necessary products and services performed both onsite at AHC and off site are documented and ordered in your chart . All ordered products and services will then be reviewed with you ASAP, a detailed Report of Findings (ROF) by an AHC clinical staff member will be performed. We also provide a Financial Consult (FC) immediately following to resolve any and all financial questions or concerns you may have involving your plan of care at AHC.

AHC takes pride in providing high quality, effective, complete healthcare for every patient. Our slogan is "*HEALTH FOR LIFE*" and that is our goal for you. Without you as a valued patient, we would not be in business..

Never hesitate to contact AHC staff or myself with questions or concerns.

Sincerely,
Edwin Davis, Jr., DC
Edwin Davis Jr., DC
PRESIDENT/CEO
Office: (912) 427-8433
Email: docedwin1@gmail.com

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible patient care, and we want you to completely understand our financial policies.

Patients with Insurance

If you have insurance, we will gladly file your claim. Deductibles and co-pays are expected at the time of service. We can only estimate the amount you owe, which is based on the information your insurance carrier provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Insurance claims outstanding 30 days or more will become your responsibility to pay.

Patients with no Insurance

Full payment is expected on the day of service.

Treatment Plans

Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

Missed Appointments

We reserve the right to charge ***$25.00*** for appointments cancelled or missed without 24 hours notice. Example of appointments missed: Medical Follow Up, Diagnostic testing (Vascular, NCV/EMG, Diagnostic Ultrasounds, Etc.) and Physical Therapy. This charge must be paid before another appointment can be scheduled. Arriving ***5 minutes*** or more after your scheduled appointment could result in rescheduling your appointment **without a missed appointment charge.**

Returned Checks

Returned checks will be subject to a ***$35.00*** service fee and charges for any bank fees. This must be paid along with the amount of the check before another appointment can be scheduled. Legal action will take place after 30 days.

Statement of Services

Statement of Services is due upon receipt. We consider an account delinquent after 30 days, and may be assessed a $5.00 per month service charge. Accounts 60 days past due are transferred to collection status. We reserve the right to use outside sources to collect on any past due accounts. You will be responsible for all costs, including attorney fees, court fees, $100.00 administrative fee, etc.

Assignment and Release of Information

I assign the benefits from my insurance carrier to Advanced Healthcare for the health benefits I am entitled for any services furnished to me. I authorize Advanced Healthcare Center to release to my insurance carrier any information needed to determine benefits for my care.

Payment Plan Options:

Every patient at AHC will receive a detailed financial consultation regarding their out of pocket expenses. We offer a variety of payment plan options including hardship agreements when applicable. We make care affordable for everyone.

Authorization

I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time-to-time.

(Please Print)Name of Patient: _____

Signature of patient (or responsible party, if patient is a minor or has a legal guardian):

Signature: _____Date: _____

ADVANCED HEALTHCARE CENTER

391 South 1st Street
Jesup, GA. 31545
Phone: 912-427-8433
Fax: 912-427-9851

Assignment of Benefits Form

Name of Insured (print):_____

Birth date:_____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Advanced Healthcare Center and its rendering providers for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Advanced Healthcare Center and its rendering providers, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by Advanced Healthcare Center.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify Advanced Healthcare Center of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Advanced Healthcare Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of Advanced Healthcare Center Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

ADVANCED HEALTHCARE CENTER AND PROVIDERS ARE NOT ENROLLED IN MEDICAID AND WE DO NOT FILE CLAIMS*** I UNDERSTAND THAT ADVANCED HEALTHCARE CENTER PROVIDERS AND SERVICES ARE NOT REIMBURSED BY MEDICAID. I WILL BE RESPONSIBLE FOR ANY BALANCES FROM SERVICES RENDERED BY ANY PROVIDERS THAT MY INSURANCE DOES NOT REIMBURSE.

Advanced Healthcare Center
391 South 1st Street
Jesup, GA. 31545

Date: _____

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

PATIENT REGISTRATION

ADVANCED HEALTHCARE CENTER

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #:_____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE:_____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY:_____

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT:_____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP:_____

BUSINESS PHONE # : _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

Edwin F. Davis, Jr., DC
Chiropractor/Owner

Sandra K. Bohnstengel, MD
Medical Director

Tracy Pritchard, FNP-C
Family Nurse Practitioner

Davina Simmons
Practice Administrator

ADVANCED HEALTHCARE CENTER

General Consent for Care and Treatment Consent

TO THE PATIENT: This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner or Physician Assistant), Doctor of Chiropractic, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and 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 test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name: _____

Signature: _____ **Date:** _____

Radiology Fee

This contract is a legal binding agreement between the patient (Name :_____) and Advanced Healthcare & Spine Institute. The patient agrees and consents that all the entire X-Ray series preformed and provided will be over read by one or more of the board certified Radiologist on staff with Hyperion Imaging, LLC. The patient further agrees to pay a separate, noninsurance reimbursable fee of $25.00 per study area for the above Radiology over read with a written report. This agreement has been reviewed, signed, and agreed by both parties.

Patients Name:_____Date:_____

Patients Signature: _____Date:_____

FOR WOMEN ONLY:

Should X-rays be necessary we would like to confirm you are not pregnant at this time

Name:_____Date:_____

- There is a possibility I might be pregnant
- Yes, I am definitely pregnant
- No, I am definitely NOT pregnant
- I request the x-ray films NOT to be taken because:_____
  _____

Date of last menstrual cycle: _____

Patient Signature:_____Date_____

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Advanced Healthcare Center in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Print Name:_____ **Birth date:** _____

Signature of Insured / Guardian: _____ **Date:** _____

Advanced Healthcare Center Controlled Substance Agreement

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 my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

_____2.) Refills of controlled substance medications

_____a) Will be made only during regular office hours Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.

_____b) Will not be made as an "emergency", such as a Thursday afternoon because I suddenly realized that I will run out tomorrow and the office will be closed. I will call at least (72) hours in advanced if I need assistance with a controlled medication prescription.

_____3) I understand the importance of following my treatment plan as directed by my physician/provider and agree:

a) To keep my appointment (including follow-up and any referrals

b) To permit urine drug screening once a month and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____4) 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 potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____5) Fails to comply with medical evaluation and recommended treatment options of pain complaints ordered by AHSI providers such as: Diagnostic tests requested (e.g., Radiology tests, NCV/EMG, EKG) physical therapy, Durable Medical Equipment, Compound topical creams, chiropractic care, pain management, etc.) Your prescriptions for controlled medications may be terminated immediately.

_____6) I understand that all the controlled substances must be obtained at the same pharmacy, when possible.

Pharmacy Name: _____

Phone Number: _____

_____ 7) I understand that if I violate any of the conditions listed below, my prescriptions for controlled medications may be terminated immediately and may be subject to dismissal from this facility. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, or sharing/permitting others (including your spouse or family members, who have access to any controlled substance that you have been prescribed). I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

NOTE: We are capable of monitoring your medications through The Georgia Prescription Drug Monitoring Program. If we suspect, or feel you have compromised your controlled substance contract with Advanced Healthcare & Spine Institute, we are obligated to use the website for confirmation.

DRUG SCREENS: Urine specimen is collected in the clinic. Patients should not wear coats and other outer clothing or take purses, bags, backpacks into the bathroom. The nurse or provider should confirm promptly that the specimen is appropriately warm and should send it directly to the lab, not give it to the patient to deliver. Drug screens with abnormal results such as:

- ***Prescriptions patient reports taking daily are not detected on screen.***
- ***Patient tests positive for controlled substances not prescribed by clinic.***
- ***Patient tests positive for illicit substances, particularly cocaine – patients should be referred for drug treatment.***
- ***Patient's drug screen shows negative for drugs prescribe.***

After retrieving lab confirmation, it will be determined if the patient should be terminated immediately or may be subject to dismissal from this facility.

Due to the recent law, concerning controlled substances, we at Advanced Healthcare & Spine Institute, will be instituting the following policies effective immediately. All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with

****This includes the following:***

- ***All forms of hydrocodone – (Vicodin, Lorcet, Lortab, Norco, Ect.)***
- ***All forms of oxycodone- (Percocet/Percodan, OxyContin, Tylox)***
- ***Most muscle relaxers- (Valium, Soma, Etc.)***
- ***Duragesic, Fentanlyl patches***
- ***Most sleeping agents- (Ambien (Zolpidem), Lunesta, Ect.)***
- ***All Benzodiazepines- (Klonopin (clonazepam), Restoril (temazepam), Serax (Oxazepam), Xanax (Alprazolam)***
- ***Codeine Preparations (Tylenol # 3, Tussionex)***
- ***Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)***

INCLUDING: (Concerta, Ritalin (methylphenidate- any brand), Adderall, Dextroamphetamine , and Vyvanse. We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature _____ Date: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release information to the family members indicated below. This consent form will allow Advanced Health Care to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize Advanced Health Care to release my medical/billing information to the following individual(s).

1._____ Relationship to patient:_____

2._____ Relationship to patient:_____

3._____ Relationship to patient:_____

Patient Name:_____

Patient Signature:_____ Date:_____

391 South First Street, Jesup, Georgia 31545

Phone (912) 427-8433 | Fax (912) 427-9851 | www.AHCforHealth.com

ADVANCED HEALTHCARE CENTER
Health For Life

Phone (912) 427-8433 FAX (912) 427-9851

MEDICAL RECORDS RELEASE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Birth Date: _____

Address: _____City:_____ State:_____ Zip: _____

Phone Number: _____ Alternate: _____

I authorize: _____

Address: _____ FAX: _____

to disclose/release the following information: (check all applicable):

- ❑ All records
- ❑ Specific records:_____
- ❑ X-Ray/Radiology Records
- ❑ Laboratory/Pathology records

Note: *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):_____

❑ Please send the records listed above to :

Name: ADVANCED HEALTHCARE CENTER
Address: 391 SOUTH FIRST STREET
JESUP, GEORGIA 31545
Phone: (912) 427-8433
Fax: (912) 427-9851

- ❑ For my health care
- ❑ For payment/insurance
- ❑ For legal purposes
- ❑ Other _____

This authorization shall expire one year after signing or upon the following event_____(whichever is sooner), and may not be valid for greater than one year from the date of signature for medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative and Relationship Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has already executed it, by sending your written request to the custodian of records.

HIPAA Notice of Privacy Practices
Advanced Healthcare Center
391 S 1st St, Jesup, GA 31545
912-427-8433

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that my identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of your physicians practice, and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians' practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations includes as Required by Law; Public Health Issues as required by law; Communicable Disease Health Oversight, Abuse, or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Worker's Compensation; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.
Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as directed in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

Complaints
You may complain to personnel at our office or the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact with your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____ Date: _____