Patient Registration Form

Please Complete All Information

Appointment Date: ___________

Patient Information

Last Name: ______________________ First Name: ______________________ M.I.: ______

Date of Birth: _____/_____/_____ Age: ______ SSN: _____-_____-_____ Sex: ______ Marital Status: ______________

Race: ______________ Ethnicity: ______________ Pref. Language: ______________

Address: ____

Email: ______________________ Home Phone: ____________ Cell Phone: ____________

Occupation: ______________________ Employer: ______________________

Employer Address: ______________________________ Employer Phone: ____________

Primary Care Physician: ______________________ Referring Physician: ______________________

Pharmacy Name: ______________ Pharmacy Address: ______________________

Pharmacy Phone: ______________ Rx Card Number: ______________________

Emergency Contact: ______________________ **Relationship to Patient:** ______________________

Emergency Contact Primary Phone: ______________ Secondary Phone: ______________

Primary Insurance

Please provide a copy of insurance card.

Insurance Carrier: ______________________ Policy ID#: ____________ Group #: ____________

Insurance Effective Date: _____/_____/_____ Insurance Co Phone: ______________

Address: ____

Subscriber's Name: ______________________ Relationship to Patient: ______________

Address (if different from patient): ______________________________ Subscriber's Phone: ____________

Subscriber's Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Subscriber's Employer: ______________

Secondary Insurance

Please provide a copy of insurance card.

Insurance Carrier: ______________________ Policy ID#: ____________ Group #: ____________

Insurance Effective Date: _____/_____/_____ Insurance Co Phone: ______________

Address: ____

Subscriber's Name: ______________________ Relationship to Patient: ______________

____ ______________________

Signature of Patient or Guardian Date

Phone 732.702.1039
Fax 732.548.7408

187 NJ-36, #230,
West Long Branch,NJ 07764

Consent for Use and Disclosure of Protected Health Information (PHI)

Use and Disclosure of PHI

Your PHI will be used by Allied Digestive Health, or disclosed to other authorized third parties, for the purpose of treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice.

Requesting a restriction on the Use or Disclosure of your information

You may request a restriction on the use or disclosure of your protected health information. Allied Digestive Health may agree to restrict the use or disclosure of your protected health information. If ADH agrees to your request, the restrictionwill be binding on practice as a whole. Unauthorized use and disclosure of PHI is a violation of an agreed upon restriction and will be a violation of federal privacy standards.

I give consent to be contacted in the following manner:

Primary Phone: ______________________

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing**

Secondary Phone: ______________________

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing**

Other persons authorized to receive my health information:

Name:____Relationship:______________________Phone:______________________

Name:____Relationship:______________________Phone: ______________________

Revocation of Consent

You may revoke this consent for the use and disclosure of your Protected Health Information at any time. You may revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocationof consent is received will not be affected.

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose myProtected Health Information in accordance with these guidelines.

____ ______________________

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian

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Fax 732.548.7408

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West Long Branch, NJ 07764

Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

Patient Name: ______________________________

- I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.
  Please note: A Doctor's Prescription is NOT a valid Referral.
- I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co- pays, co-insurances, deductibles, and non-covered services.
- I understand that if I do not have valid medical insurance, I am financially responsible for all fees for provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.
- I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.
- I will provide all current insurance ID cards (we require both sides of your insurance card) at the time of service as well as a current photo ID.
- I understand that I will be charged $35 for any check returned by my bank for any reason.

Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to Allied Digestive Health for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. **I understand that I am ultimately financially responsible for payment of all services regardless of any insurance coverage that I may have.** A photocopy of this authorization shall be considered as effective and valid as the original.

Release of Medical Records and Information

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company, or other authorized third parties involved in my case unless I have specifically instructed otherwise.

By my signature below, I acknowledge that I understand and agree to these terms:

______________________________ ______________________________
Signature of Patient or Guardian Today's Date

Allied Digestive Health

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Card on File Agreement

Maximum Charge Amount in one year: $1,500.00

This is not a receipt. This is an agreement to pay for services once patient liability has been determined. The terms of this agreement are outlined below.

AGREEMENT TERMS

Effective date:
Expiration date:

I agree to allow the practice to charge my credit card during the effective period for the balance due, as determined by the final adjudication of all claims included under this contract. I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I agree to these charges under the following conditions:

- The charges will take place upon receipt, or within a few days, of the final explanation of benefits from my insurance company
- The amount charged to my card will not exceed the agreed-upon maximum dollar amount
- My credit card will be stored by Elavon, Inc., a secure credit card processor affiliated with U.S. Bank that partners with the practice to collect payments
- I will receive a bill from the practice for any balance greater than maximum dollar for which I am liable.
- I will receive a receipt for any amount charged to my card once the transaction has been executed

☐ I Accept
☐ I Decline

Date of visit:

Maximum charge amount: $1,500
Effective date: 01/31/23
Expiration date: 01/31/24

I agree to allow Allied Digestive Health to charge my credit card for any amount not covered by insurance (up to the maximum charge amount), for all services provided by Allied Digestive Health to the patient(s) on or after the effective date and before the expiration date. I acknowledge that:

- My credit card will be charged upon review of the final expiration of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $1,500.00 has been charged to my credit card under this agreement, Allied Digestive Health will bill me directly for any amounts not covered by insurance
- My credit card will be stored by Elavon, Inc., a secure credit card processor affiliated with U.S. Bank that partners with Allied Digestive Health to collect payments.
- I will receive receipts detailing the amount charged.
- I may cancel this agreement at any time by contacting Allied Digestive Health, any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be billed to me directly.

Signature of Patient or Guardian ____________________ Today's Date ____________

Printed name of Patient or Guardian ____________________

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Patient HIPAA Consent Form

Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information (PHI). The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

Changes to Notice of Privacy Practices

The terms of the notice may change. If so, Allied Digestive Health will post any revised notice in our registration area and on our website.

Requesting a Restriction on the Use or Disclosure of PHI

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows for the use of your protected health information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. Allied Digestive Health is not required to agree with this restriction, but if we do, the restriction will be binding on the practice as a whole.

By signing this form, I understand that:

- My protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Allied Digestive Health reserves the right to change its Notice of Privacy Practices from time to time and will post any revised notice in its registration area or on its website.
- I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
- I have the right to revoke this consent in writing, except to the extent that you have taken action relying on this consent.

By signing this form, you consent to our use and disclosure of your protected health information and to be contacted in the following manner:

Primary Telephone # ________________

- ☐ Ok to leave a voicemail message to **call back only**
- ☐ Ok to leave a voicemail message **with results and detailed information, including billing.**

Secondary Phone # ________________

- ☐ Ok to leave a voicemail message to **call back only**
- ☐ Ok to leave a voicemail message **with results and detailed information, including billing.**

By providing the above telephone numbers, I consent to delivery of telephone calls or text messages from Allied Digestive Health, its affiliated practices, and/or third parties acting on behalf of Allied Digestive Health to me at the phone numbers I have provided above for appointment reminders or cancellations, billing, payment and account reminders, patient satisfaction

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surveys, invitations to take part in mobile applications that assist with my treatment, and other informational messages. These calls and text messages may be made using an automatic telephone dialing system or prerecorded or artificial voice.

Other persons authorized to receive my health information:

Name: ___________________________Relationship: __________________

Name: ___________________________Relationship: _________________

Revocation of Consent

You have the right to revoke this consent at any time in writing, signed by you. However, such a revocation will not be retroactive and any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose my Protected Health Information in accordance with these guidelines.

______________________________________ _______/______/_______
Signature of Patient or Patient Representative Date

____
Printed Name of Patient

Relationship to patient (if minor): ________________________________

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Office Policies

Cancellation Policy

As all our patients are valuable to us, so is our time with them. We ask that appointments for office visits be cancelled at least 3 days prior to the appointment and procedures be cancelled at least 7 days prior to the appointment unless for medical reasons in order to allow other patients to utilize this time. If this policy is not honored, a $50 cancellation fee for office visits and a $100 cancellation fee for procedures may be added to your account (your insurance will not cover this fee). After 3 missed appointments, you may no longer be treated in our office.

Referrals

It is your responsibility to obtain a referral if required by your insurance AND it is due at the time of service. If you do not have your referral, we will reschedule your appointment. This is a requirement of YOUR insurance company.

Co-pay

If a co-pay is required by your insurance, it is due at the time of service. Please note, we accept cash, credit cards, or checks. There is a $35.00 charge for returned checks.

Statements

It is your responsibility to verify your insurance rules and regulations regarding procedures. The practice has no control over what your insurance will or will not allow. The practice is not responsible for any charges for doctors, facilities, anesthesia, lab or pathology not covered by your insurance. We recommend contacting your insurance for clarification on your insurance coverage.

______________________________ Signature of Patient or Guardian

______________ Today's Date

______________________________ Printed name of Patient or Guardian

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date: ______________________

Date of Birth: ______________________ Social Security #: ______________________

I request and authorize ____________________ to release healthcare information of the patient named above to:

Name: ______________________________________ Phone: ____________________

Address: ______________________________________ Fax: ____________________

City: ______________________________________ State: __________ Zip Code: __________

I authorize this information to be faxed (when applicable) ☐ Yes ☐ No Client Initials: ____________

This request and authorization applies to (check below):

☐ Healthcare information relating to the following treatment, condition, or dates:

____

☐ Other: ____

Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, such information about me will be released if it exists.

☐ HIV/AIDS ☐ Genetic Information ☐ Treatment for alcohol and/or drug abuse

☐ Mental Health ☐ Sexually Transmitted Disease(s)

Without my express revocation, I understand that this authorization will expire in one (1) year from the date signed unless indicated below:

- ☐ Under the following condition(s):____
- ☐ Upon satisfaction of the need for disclosure
- ☐ On________________(*enter a future date other than date signed by patient not to exceed 1 year)*

I understand that once my medical records leave this practice, there is a potential for redisclosure by the recipient if they are no longer protected by the Privacy Rule.

I may revoke this authorization in writing but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment ormy eligibility for benefits, unless otherwise described in the space provided here:
____

Patient Signature: ______________________________ Date Signed: ____________________

Parent/Legal Guardian Signature: ____________________ Date Signed: ____________________

Personnel Signature: ____________________________ Date Signed: ____________________

Please allow 30 days for your request to be processed and records to be sent

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes our legal duties and the health information privacy practices of our medical group, its medical staff and affiliated health care providers who jointly perform health care services with our medical group, including physicians and physician groups who provide services at our facilities. We are also required to notify affected individuals in the event of an unsecured breach of protected health information. A copy of our current notice will always be posted at all registration and/or admission points, including in the main reception area. You will also be able to obtain your own copies by accessing our website at www. allieddigestivehealth.com, our Documents Management Department or the Privacy Officer 844-932-6675 or 187 Hwy 36, S/230, West Long Branch, NJ 07764. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient of our medical group or receiving health-related services from our facilities, information about your health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

REQUIREMENT FOR WRITTEN AUTHORIZATION

Generally, we will obtain your written authorization before using your health information or sharing it with others outside of our medical group. There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

- **Most Uses of Psychotherapy Notes**: when appropriate.
- **Marketing:** We may not disclose any of your health information for marketing purposes if our medical group will receive direct or indirect financial payment not reasonably related to our medical group's cost of making the communication. Written authorization is not required for communications made face-to- face or communications in the form of a promotional gift of nominal value.
- **Sale of Protected Health Information:** We will not sell your protected health information to third parties unless permitted under HIPAA. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive payment for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical group's behalf, or for other purposes as required and permitted by law.

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WRITTEN AUTHORIZATION

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to our Privacy Officer, Beverly Coleman; who can be reached by phone 732-702-1039 ext. 1055 or by email bcoleman@allieddigestivehealth.com. You may also initiate the transfer of your records to another person by completing a written authorization form.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment, Payment and Health Care Operations.

- **Treatment:** We may share your health information with providers at the medical group who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A provider in our medical group may share your health information with another provider to determine how to diagnose or treat you. Your provider may also share your health information with another provider to whom you have been referred for further health care.
- **Payment:** We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.
- **Health Care Operations:** We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates. We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information. If our business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

Friends and Family Designated to be Involved in Your Care . If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Proof of Immunization. We may disclose proof a child's immunization to a school, about a child who is a student or prospective student of the school, as required by State or other law, if a parent, guardian, other person acting in loco parentis, or an emancipated minor, authorizes us to do so, but we do not need written authorization. The authorization may be oral.

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Emergencies or Public Need.

- **Emergencies or as Required by Law:** We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you. We may use or disclose your health information if we are required by law to do so, and we will notify you of these uses and disclosures if notice is required by law.
- **Public Health Activities:** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, including maintaining vital records, such as births and deaths, notifying a person regarding potential exposure to a communicable disease, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting reactions to drugs or problems with products or devices, notifying individuals if a product or device they may be using has been recalled, and notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- **Victims of Abuse, Neglect or Domestic Violence:** We may release your health information to a public health authority authorized to receive reports of abuse, neglect or domestic violence.
- **Health Oversight Activities:** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.
- **Lawsuits and Disputes:** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if required judicial or other approval or necessary authorization is obtained.
- **Law Enforcement:** We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, if we suspect that your death resulted from a crime, or if necessary, to report a crime that occurred on our property or off-site in a medical emergency.
- **To Avert a Serious and Imminent Threat to Health or Safety:** We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).
- **National Security and Intelligence Activities or Protective Services:** We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.
- **Military and Veterans:** If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **Inmates and Correctional Institutions:** If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.
- **Workers' Compensation:** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

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- **Coroners, Medical Examiners and Funeral Directors.** In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.
- **Organ and Tissue Donation:** In the event of your death or impending death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Completely De-identified or Partially De-identified Information: We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de- identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Changes to This Notice: We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. Any revision or amendment to this notice will be effective for all of your records we have created or maintained in the past, and for any of your records we may create or maintain in the future.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

1. **Right to Inspect and Copy Records:** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. If you would like an electronic copy of your health information, we will provide you a copy in electronic form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed. In some limited circumstances, we may deny the request.
2. **Right to Amend Records.** If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records by writing to us. Your request should include the reasons why you think we should make the amendment. If we deny any part of or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.
3. **Right to an Accounting of Disclosures**: You have a right to request an "accounting of disclosures," which is a list with information about how we have shared your health information with others. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer. You have a right to receive one list every 12-month period for free. However, we may charge you for the cost of providing any additional lists in that same 12-month period.
4. **Right to Receive Notification of a Breach:** You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the

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investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

Right to Request Restrictions: You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. You also have the right to request that your health information not be disclosed to a health plan if you have paid for the services out of pocket and in full, and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. To request restrictions, please write to the Privacy Officer. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the

1. Right to Revoke: You have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so.
2. Right to Request Confidential Communications**:** You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home, by notifying the registration associate who is assisting you. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.
3. Right to Have Someone Act on Your Behalf**:** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.
4. Right to Obtain a Copy of Notices: If you are receiving this Notice electronically, you have the right to a paper copy of this Notice. We may change our privacy practices from time to time. If we do, we will revise this Notice and post any revised Notice in our registration area and on our website.
5. Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us by calling the Privacy Officer or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.
6. Use and Disclosures Where Special Protections May Apply: Some kinds of information, such as HIV-related information, alcohol and substance abuse treatment information, mental health information, psychotherapy information, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Right to Provide an Authorization for Other Uses and Disclosures: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note that we are required to retain records of your care.

Effective June 7, 2022