NEW JERSEY UROLOGY
Excellence In Care

Patient Registration Form

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Gender:** ☐Male ☐Female ☐Other

Race: ☐African American/Black ☐American Indian/Alaskan Native ☐Asian ☐Caucasian/White
☐Native Hawaiian/Pacific Islander ☐Other _____ ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown ☐Declined

Primary Language: _____ **Marital Status:** ☐Single ☐Married ☐Widowed ☐Separated

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Street Address: _____

City: _____ **State:** _____ **ZIP:** _____ **County:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____ **Preferred Communication:** _____

Emergency Contact: _____

Relationship: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Address: _____ **Fax #:** _____

Primary Care Physician: _____ **Phone:** _____

Address: _____ **Fax #:** _____

Pharmacy Name: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

Is patient at a Skilled Nursing Facility? NO YES _____
Name of Skilled Nursing Facility

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy #: _____ **Group #:** _____

Subscriber / Insured's Name: _____ **Date of Birth:** _____

Subscribers SSN #: _____ **Relationship to Insured:** _____

Does your insurance require a referral? ☐Yes ☐No

Secondary Insurance Company: _____

Policy #: _____ **Group #:** _____

Subscriber / Insured's Name: _____ **Date of Birth:** _____

Subscribers SSN #: _____ **Relationship to Insured:** _____

Does your insurance require a referral? ☐Yes ☐No

WORKERS COMPENSATION INFORMATION (If applicable)

Workers' Compensation Insurance: _____

Employer's Name _____ **Address:** _____

Adjuster's Name: _____

Claim #: _____ **Phone #:** _____

NO FAULT INFORMATION (If applicable)

No Fault Insurance: _____

Claim #: _____ **Phone #:** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize New Jersey Urology or my insurance company to release any information required to process my claims. I understand that I am financially responsible for any amount not covered by insurance. I have been informed that copays, deductibles, and any outstanding balances are expected at the time of visit.

_____ _____

Patient Signature **Date**

_____ _____

Authorized Representative Signature **Date**

NEW JERSEY UROLOGY
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Financial Policy

We at New Jersey Urology, LLC are committed to providing you with the best possible care and ask that you please review the financial information below and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Services and Referrals:** It is your responsibility to understand your insurance coverage, policy provisions, exclusions and limitations as well as authorization and referral requirements. If your insurance requires a referral from your primary physician, you must present this when you arrive for your appointment. Without a referral you will not be able to see your doctor.

4. **Non-Covered Services and Supplies:** Please be aware that some services and supplies you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be responsible for payment of these services or supplies in full.

5. **Proof of Insurance**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **ClaimsSubmission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage Changes**. You are responsible for notifying us of any changes in your insurance. Failure to do so may result in a denial of coverage and fees for which you will be held responsible.

8. **Missed Appointment:** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Payment:** You are responsible for all required payment of services based on the information outlined in policy items 1-8 above. If your insurance company pays you directly you must send payment to our office along with the corresponding Explanation of Benefits (EOB). Should your account become delinquent after 90 days we may refer your account to a collection agency which may incur additional fees that will become your responsibility.

Our practice is committed to providing the best treatment to our patients. Should you have any questions regarding our financial policy, please do not hesitate to ask.

I have read and understand the financial policy above and agree to abide by its guidelines:

_____

(Print Name)

_____ _____

(Signature of Patient or Responsible Party) (Date)

revised 11-28-17

NEW JERSEY UROLOGY
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ASSIGNMENT OF BENEFITS

I hereby assign and convey directly to New Jersey Urology (NJU), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by NJU, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize NJU to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to NJU any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from NJU or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to NJU any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from NJU (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to NJU all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by NJU, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (NJU) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. NJU as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

FINANCIAL AGREEMENT
I understand that if NJU does not participate with my insurance payer, and I still wish to be seen, I can be seen as a "Self-Pay" patient. I understand that I will be required to pay the total cost of the visit in advance. NJU may courtesy file a claim to my non-participating insurance on my behalf or a claim form will be provided to me by the Billing Office.

NON-COVERED SERVICES
I understand that NJU's contracts with health care insurance carriers and other payers relate only to items and services which are "covered" by the health benefits carriers and other payers. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health benefits carrier or other payers not to be covered. Examples of services not eligible for payment include, but are not limited to, services which are determined as not medically necessary, non-covered, experimental or not otherwise specified as being covered in the patient's contract or in a benefit summary furnished to the patient beneficiary.

REFERRALS
I understand that it is my responsibility to know whether my insurance plan requires a referral. If so, I'm required to obtain a valid referral from my Primary Care Physician (PCP) prior to receiving medical services at NJU. I understand without the appropriate referral, I am responsible for payment for these services.

APPOINTMENT CANCELLATION
I understand that if I need to cancel or reschedule my appointment, I need to do so a minimum of twenty-four (24) hours in advance of my scheduled appointment time. **Failure to comply may result in an appointment cancellation fee.**

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been provided with a copy of NJU's Notice of Privacy Practices, which describes how medical information about me may be used and disclosed and how I can have access to this information.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (20%), attorney fees and/or court costs, if such be necessary.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):
You agree, in order for us to service your account or to collect monies you may owe, NJ Urology, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provided to us. Method of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that NJ Urology, its employees and/or agents may contact me/us as described above.

Responsible Party Signature _____ Date _____

revised 11-28-17

NEW JERSEY UROLOGY
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HEALTH HISTORY

NAME _____ DOB ___/___/___ AGE _____

PHARMACY NAME AND PHONE # _____

To help us meet all your healthcare needs, please fill out this form completely. This is confidential record of medical history.

CHIEF COMPLAINT: What is the **MAIN REASON** for your visit? **WHEN** did you first notice the problem, the **LOCATION** of the problem, **HOW LONG** the symptoms last, is it **CONSTANT** or **VARIABLE**, does anything make **BETTER OR WORSE**, and a **NUMBER SCORE** (between 1-10, 1 being least and 10 being most severe) that best describes the severity of the problem..

_____

_____

_____

_____

_____

HEIGHT: _____FT _____IN **WEIGHT:** _____LBS

PAST MEDICAL HISTORY - Have you ever had a diagnosis of the following (describe): _____ NONE

☐ Cancer_____	☐ Irritable Bowel Syndrome_____	☐ Lung _____
☐ Heart _____	☐ Elevated Cholesterol_____	☐ Fibroids/ovarian cysts_____
☐ Stroke/TIA_____	☐ Bleeding Disorders _____	☐ High blood pressure_____
☐ Thyroid Disease _____	☐ Low testosterone _____	☐ Gout _____
☐ Glaucoma _____	☐ Diabetes Type I _____	☐ GERD/Reflux _____
☐ Tuberculosis _____	☐ Diabetes Type II _____	☐ Hepatitis (type) _____
☐ Kidney stone_____	☐ Enlarged Prostate _____	☐ HIV/AIDS _____
☐ Genital warts/STD's_____	☐ Urinary tract infections _____	☐ Elevated PSA _____
☐ Breast _____	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____	☐ Other_____

PAST SURGICAL HISTORY - Have you ever had a diagnosis of the following (describe): _____ NONE

☐ Appendix _____	☐ Heart _____	☐ Hernia Repair _____
☐ Back Surgery_____	☐ C-Section _____	☐ Hysterectomy _____
☐ Breast _____	☐ Gastric Surgey_____	☐ Thyroidectomy _____
☐ Cataract _____	☐ Gallbladder _____	☐ Tonsil/Adnoids _____
☐ Colon _____	☐ Prostate _____	☐ Vasectomy _____
☐ Sling _____	☐ Cystocele/rectocele _____	☐ Kidney stone _____
☐ Other_____	☐ Other _____	☐ Other _____

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MEDICATIONS: Please list all medicines you are currently taking _____ NONE

CURRENT MEDICATIONS:	Dosage (mg)	how often per day?

ALLERGIES (food, drugs, and environment) _____ NONE KNOWN

FAMILY HISTORY: Has any blood relative (mother, father, sister, brother, aunt, uncle, maternal or paternal grandmother/grandfather) had any of the following: (check box, leave blank if uncertain)

	Relationship
☐ History of heart disease (heart attacks, heart failure)?	
☐ History of strokes/blood clots?	
☐ History of high blood pressure?	
☐ History of diabetes/high blood sugar?	
☐ History of high cholesterol?	
☐ History of Cancer? If so, site?	
☐ History of thyroid disease?	

OCIAL HISTORY:

Tobacco: ☐ never ☐ minimal (social) ☐ yes (____packs/day x ____yrs) ☐ quit ____yrs ago

Alcohol: ☐ never ☐ rarely ☐ less than 10 per week ☐ more than 10 per week

Illicit drug ☐ No ☐ Yes what type: _____

Excercise: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Active but no formal excercise

IENSTRUAL HISTORY (females only)

Age at Menstruation _____ Age at menopause _____

Pregnancies _____ # Vaginal deliveries _____ # C-sections _____

Miscarriages _____ # Abortions _____

Are you sexually active? Yes ____ No ____

Are you on Hormone replacement therapy? Yes ____ No ____

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REVIEW OF SYSTEMS

Please circle any of the following symptoms that are relevant to you
If you do not have any of the symptoms, circle "no problems"

Constitutional:

no problems
poor appetite
weight loss
weakness
fatigue
malaise
fever
chills
sweats
pain

Neurological:

no problems
numbness
difficulty walking
headaches
tremors
balance problems
fainting
forgetfulness
paralysis

Heart/Blood Vessels:

no problems
palpitations
irregular heart beat
chest pain
buttock pain walking
leg swelling

Ear/Nose/Throat:

no problems
sinus problem
hearing loss
ringing in ear
nosebleeds

Gastrointestinal:

no problems
change in bowel habit
constipation
diarrhea
nausea/vomiting
blood in stool
black stools
exccesive gas
heartburn
jaundice
fecal incontinence

Skin:

no problems
moles/lesions
rashes
hair loss

Eyes:

no problems
visual impairment
blurry vision
double vision
eye pain

Musculoskeletal:

no problems
muscle weakness
muscle pain
neck/back ache
joint pain
bone pain

Endocrine:

no problems
excess thirst
excess urine
hyperactivity
sluggishness
excessive body hair
male-enlarged breast
nipple discharge
loss of facial/body hair
loss of muscle strength
increased body fat

Psychiatric

no problems
anxiety
depression
mania
alchoholism
insomnia
eating disorder
mood changes

Hematological:

no problems
easy bruising
clotting problems
bleeding tendency
swollen lymph glands

Respiratory:

no problems
cough
coughing blood
shortness of breath
tuberculosis exposure

NEW JERSEY UROLOGY
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Urinary review of systems: (circle all that apply and fill in the blanks where indicated)

NO URINARY COMPLAINTS

Have you been diagnosed with or treated for:

Visible blood in urine (start of stream, end of stream, entire stream, no pain)
Urinary infections
Urinary retention
Kidney cancer
Microscopic blood in urine
Kidney mass
Kidney obstruction
Kidney stones
Kidney infections
Prostate cancer
Bladder cancer

Do you have:

Painful urination
burning with urination
difficult urination
frequent urination
urgent urination
night time urination
# of times _____

difficulty urinating at night
but not during the day

foul smelling urine
air in urine
stool in urine
cloudy urine
urethral discharge
incomplete emptying
flank pain
groin pain

hesitant stream
need to strain to pass urine
weak stream
spraying/split stream
stream starts/stops
long time to empty
dribbling after urination
burning after urination

need to urinate twice or
more to empty

Leakage issues:

on the way to the toilet
with running water
getting out of the car
sitting quietly
running
laughing
lifting
playing sports

putting the key in the door
without realizing it
during intercourse
continuous leakage
sneezing
shouting
bending

in cold weather
while sleeping
with orgasm
walking
coughing
climbing stairs
standing
dribbling after urination

#_____ of pads per day

_____ of liners per day

_____ of diapers per day

Gynecological (for females only):

excessive menstrual bleeding
excessive menstrual cramping
sexually transmitted diseases

no problems
bulge coming out of vagina
lubrication problems
genital rash or lesions

lax vagina
painful intercourse
breast lumps

Males only: *no problems*

loss of sexual desire
difficulty achieving an erection
difficulty maintaing an erection
painful erections
prolonged erections
angulated erections
decreased sensation with orgasm
blood in semen

Are you sexually active: yes no

premature ejaculation
delayed ejaculation
inability to ejaculate
painful ejaculation
foreskin difficulties
abnormal penile opening
infertility
sexually transmitted disease

undescended testicle
lump on testicle
testes hang too low
painful testicle(s)
absent testicle(s)
shrinking penis
penile rash or skin abnormality

Any other unlisted problems:

_____

_____

_____

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International Prostate Symptom Score (I - PSS)

Patient's Name _____ Date of Birth _____ Date Completed _____

In the past month	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your Score
1. Incomplete Emptying How often have you had the senasation of not emptying your bladder	0	1	2	3	4	5	
2. Frequency How often have you had to urinate again less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to push or strain to start urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms?	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

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ADAM Questionnaire

Please circle YES or NO to each of the following questions

1. Do you have a decrease in libido (sex drive)?	YES	NO
2. Do you have a lack of energy?	YES	NO
3. Do you have a decrease in strength and/ or endurance?	YES	NO
4. Have you lost height?	YES	NO
5. Have you noticed a decreased "enjoyment of life"?	YES	NO
6. Are you sad and/or grumpy?	YES	NO
7. Are your erections less strong?	YES	NO
8. Have you noticed a recent deterioration in your ability to play sports?	YES	NO
9. Are you falling asleep after dinner?	YES	NO
10. Has there been a recent deterioration in your work performance?	YES	NO

NJU ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practice which provides information about how we may use and disclose protected health information(PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

☐ I acknowledge that I have received a copy of the NJ Urology Notice of Privacy Practices.

☐ We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the patient but it could not be obtained because: _____

Employee Signature/Date: _____ (For Office Use Only)

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below name(s) of the individual(s) (Family, Friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

I authorize NJ Urology to disclose my Protected Health Information to these individuals:

	Name	Relationship to Patient	Phone Number
1.			
2.			
3.			
4.			
5.			

_____ _____
Name of Patient (print) Date of Birth

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date
(Required if patient is a minor or an adult who is unable to sign this form)

_____ _____
Relationship of Patient Representative to Patient Print Name

UROLOGY **NJU Notice of HIPAA 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

Your Information, Your Rights, Our Responsibilities

Your Information

How We May Use and Disclose Medical Information About You

Treatment
- We can use your health information and share it with other professionals who are treating you.

Payment
- We can use and share your health information to bill and get payment from health plans or other entities.

Health Care Operations
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Appointment Reminders, Treatment Alternative, Health-Related Benefits and Services
- We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

Assist 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

For Research
- We can use or share your information for health research

As Required By Law
- We will disclose medical information about you when required to do so by federal, state or local law

Respond to Organ and Tissue Donation Requests
- We can share health information about you with organ procurement organizations

Work with Coroner, 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

Military and Veterans
- If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities

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

Special Privacy Protections
- If your medical information includes HIV-related information , alcohol or substance abuse, mental health or genetic information, special protections may apply to such information and you can contact us if you have any questions

Other Uses of Medical Information
- Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made with your written authorization , on an NJU authorization form. You may revoke such an authorization by writing us , and such revocation will be effective to the extent that we have not already released the information pursuant to the authorization or otherwise taken action in reliance on the authorization

Fundraising and Other Events
- We may contact you for fundraising efforts, but you can tell us not to contact you again
- We never share your information unless you give us written permission for marketing purposes, sale of your information, and most sharing of psychotherapy notes

UROLOGY **Your Rights**

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Right to Inspect and Copy
- You can request to see or get an electronic or paper copy of your medical record and other health information we have about you. This right does not include psychotherapy notes, information compiled for use in a legal proceeding, or certain information maintained by laboratories.
- 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.

Right to Request Amendments
- You can request 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.

Right to Request Confidential Communications
- You can request us to contact you in a specific way (for example, home or office phone) or to send mail to different address.
- We will say "yes" to all reasonable requests.

Right to Request Restrictions
- You can request us not to use or share certain health information to someone who is involved in your care or the payment of your care, such as a family member or friend.
- If you pay for a service or health care item out-of-pocket in full, you can request 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.

Right to an Accounting of Disclosures
- You can request 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 the same 12 month period.

Right to a Paper Copy of this Notice
- You can request 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.

Right to 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.

Right to be Notified of a Breach
- In the event of a breach of your Protected Health Information as defined by the Department of Health and Human Services (HHS), you will be notified by us in a manner specified by HHS.

Right to File a Complaint
- You can file a complaint if you feel we have violated your rights by contacting us or the US 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.

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**
- **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 or website**