FRED L. LESLIE, D.O., P.L.
SEMINOLE FAMILY HEALTH CENTER
10875 Park Blvd., Ste. C
Seminole, FL 33772
727-851-9910 Office 727-851-9949 FAX

PATIENT INFO (Please print) Today's Date: ____________________

Patient Name: ______________________________ ______________________ ________
Last First M.I.

Home/Permanent Address: ____
Street Apt. # City State Zip

DOB: _____/_____/_____ Age: __________ SS# ________-________-__________ Driver's License# ______________________

Sex: M____ F____

Home # ________________________ Cell # ______________________ Work # ________________________

E-Mail: ____

Temporary/Local Address: ____
Street Apt. # City State Zip_

Phone #: ________________________ Cell: ______________________

Preferred Contact (CIRCLE): Home Work Cell E-mail

Spouse/Responsible Party:

____
Last name First Name MI Home Phone Work Phone

____
Street Address City State Zip DOB

______________________ ______-______-______ ______ ______
Driver's Lic. # SS# Sex: Male Female

Employer: ________________________________ Occupation: ________________________

Employer Address: ____ Phone # ______________

Marital Status: Single ____ Married____ Partnered _____ Separated _____ Divorced_____ Widowed____

Patient's Employer: ________________________________ Occupation ________________________

Employer Address: ____ Phone# ______________

Emergency Contact: ________________________________ Phone #: ________________________

Address: ____ Relationship: ______________

Student Status: Full-time____ Part-Time______

If patient is a child/minor, parent or guardian's name: ____________________________________

Parent/guardian's employer, address & phone: ____

RELEASE OF INFORMATION: We will only discuss your protected health information (PHI) with you unless you authorize us to discuss it with someone else. Please list below the name(s) of individuals with whom you authorize our office to discuss your care. If this list changes, please notify us in writing.

______________________________ ______________________________

______________________________ ______________________________

I acknowledge that I have received a copy of Seminole Family Health Center's "Notices of Privacy Practices". I have read and understand the above and agree to comply.

Patient/Responsible Party's Signature: ________________________________ Date: ____/______/______

Print Name: ____

INSURANCE INFORMATION

Primary Insurance Company Name:______________________________

Address:______________________________

Phone:__________________ Subscriber:__________________ Relationship:__________

Employer:______________________________

Policy Number:______________________________ Group Number:__________________

Co-pay Amount: $__________________ Yearly Deductible: $__________________

Is this visit is related to an accident? Yes No Auto Workers' Comp. (Please circle)

Date of injury__________ The state where the injury/accident occurred. __________________

Attorney's name: __________________ Attorney's address: __________________

______________________________Attorney's phone #: __________

Secondary Insurance Company Name:______________________________

Address:______________________________

Phone:__________________ Subscriber:__________________ Relationship:__________

Employer:______________________________

Policy Number:______________________________ Group Number:__________________

Co-pay Amount: $__________________ Yearly Deductible: $__________________

Payment/Insurance Authorization and Assignment:

Where my insurance covers my illness/treatment, I hereby authorize Fred L. Leslie, D.O., P.L. to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to Dr. Fred L. Leslie, D.O. all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by insurance. This includes any course of treatment that is not a covered benefit. I understand that I am responsible for notifying Dr. Leslie's office of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be responsible for these charges.

Patient Name: ______________________________
(please print)

Patient Signature:______________________________ Date:______/______/______

FRED L. LESLIE, D.O., P.L.

FINANCIAL POLICY

Welcome to our practice. We strive to provide you with excellent medical care. Our goal is to make your visits as comfortable as possible.

- **INSURANCE:** We have applied for some insurance plans, including Medicare. If you are not insured, or not insured with a plan with which we are a participating provider, payment in full is required at each visit. If you are insured by a plan with which we are a participating provider but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Your insurance policy is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **CO-INSURANCE:** It is the patient's responsibility to pay for the balance of what his/her co-insurance does not cover.
- **CO-PAYMENTS AND DEDUCTIBLES:** All co-payments must be paid before the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.
- **NON-COVERED SERVICES:** Some of the services you receive may not be covered, considered investigational by some health plans, or not considered reasonable or necessary by some insurers. You must pay for these services in full at the time of the visit.
- **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 information in a timely manner, you may be responsible for the balance of a claim.
- **COVERAGE:** If your insurance changes, please notify us **before** your next visit so we can make the appropriate changes to help you receive your maximum benefits. We are pleased to file claims with your insurance company, but you are personally financially responsible for health care services provided to you by Dr. Leslie. If your primary insurer (or secondary in Medicare claims) does not pay your claim within 60 days of its submission, Dr. Leslie will require payment directly from you since you are personally financially responsible for health care services provided to you by Dr. Leslie. The balance will automatically be billed to you.
- **NON-PAYMENT:**
- **MISSED APPOINTMENTS:** There will be a $25 fee for missed appointments not cancelled 24 hours prior to the scheduled time for your visit. These charges will be your responsibility.
- **BOUNCED CHECKS:** There is a $25 fee plus the bank fees for any bounced or returned checks. If this is not remedied within 7 days, this matter will be referred to Small Claims Court or our attorney.
- **PAYMENTS:** At check-in, co-pays, deductibles, balances from co-insurance that is patient responsibility or non-covered services are required before being seen by the doctor. Future appointments and diagnostic testing can be rescheduled once any outstanding balances are paid. We accept cash, major credit cards, debit cards, and personal checks.

Should you have questions, please call Florida Westcoast Medical Billing at 727-287-0650 or 727-287-0660 FAX

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party____ Date__________

Print Name____

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are as follows:

PATIENT RIGHTS

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable itemized bill, and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency. You may voice a compliment or complaint by calling (727) 851-9910 or FAX (727) 851-9949, or e-mail: flesliedo@outlook.com

PATIENT RESPONSIBILITIES

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider of health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

ADVANCE DIRECTIVES

Upon registration, we will ask you if you have an advance directive. An advance directive is a written document which communicates your health care wishes clearly. There are two types of advance directives:

A Durable Power of Attorney for Health Care: It is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event that you are unable to do so. These decisions may include, but are not limited to, the withholding or withdrawal of life-prolonging procedures.

A Living Will or Health Care Directive: It is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family to the person you name as your agent.

Name of Patient	Signature of Patient	Date	Time
Name of Legal Authorized Person	Signature of Legal Authorized Person	Date	Time
Name of Witness	Signature of Witness	Date	Time

Dr. Fred L. Leslie, DO; 10875 Park Blvd, Suite C;
Seminole, FL 33772; 727/851-9910

HISTORY **DATE**

NAME **DOB**

FAMILY SOCIAL HISTORY	FATHER	MOTHER	SIBLINGS	CHILDREN		FATHER	MOTHER	SIBLINGS	CHILDREN
Heart Disease					Migraine				
High Blood Pressure					Mental Illness				
Stroke					Asthma/COPD				
Cancer					Bleeding Disorder				
Glaucoma					Anemia				
Diabetes					Osteoporosis/Arthritis				
Thyroid Disease					Kidney Disease				
Epilepsy/Convulsions					HIV				
Hepatitis									

	Living	Deceased	Age
FATHER			
MOTHER			
SIBLINGS			
CHILDREN			

Alcohol________oz./ week Coffee/Tea______cups/day
Smoking____cig/day_____# years Year you quit____________
Exercise________________
Street Drugs________________

HOSPITAL ADMISSIONS Not including Pregnancies	YEAR	SURGERIES OR ILLNESS		* ALLERGIES *	

LIST ALL MEDICATIONS & DOSAGES YOU ARE NOW TAKING

		VACCINE	Year of Last	TEST/EXAM	Year of Last
		Tetanus/Td		Rectal/Stool	
		Flu		Cholesterol	
		Pneumonia		Eye	
		Hepatitis		Colonoscopy	
		Tuberculosis		PSA	

* **MEDICAL HISTORY** MARK © FOR CURRENT PROBLEMS. CHECK √ AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES

CONSTITUTIONAL:
__Fainting spell/dizzy spell
__Weakness/weight gain/weight loss
__Migraines/headache

EARS NOSE THROAT:
__Decreased hearing/ear infections
__Ringing in ears/spinning sensation
__Nose bleeds/Chronic sinus/Tonsillitis
__Sore throat/Hoarseness/Allergies/Hay fever

CARDIOVASCULAR:
__Chest pain/Palpitations/Heart throbbing/CAD
__Arrhythmias
__AFib/Irregular pulse/ High blood pressure
__Lipid/Cholesterol
__Leg pain/Ankle swelling
__Varicose vein/Phlebitis/Blood clots or embolisms

GENITOURINARY:
__Urination – painful, frequent, burning, urgency
__Loss or urine control/Stress incontinence-leakage with exercise or movement
__Overactive bladder-overnight>twice or more than 8 times in 24 hours
__Blood in urine/Kidney stones/Frequent urinary infections
__Prostate problems (men only)
__History of Syphilis, Gonorrhea, Chlamydia

SKIN:
__Change in skin color/Rashes/Hives
__Psoriasis/Eczema/Acne
__Changes in moles/Nails/Hair

ENDOCRINE:
__Diabetes
__Thyroid disease or goiter
__Hair loss: Progressive or recent

ENDOCRINE:
__History of seizure/stroke
__History of head injury/concussion/fall
__Difficult or slurred speech/Difficulty walking
__Numbness/Tingling/Tremors/or Shaking

FEMALES:
__# of pregnancies_______, abortions________
miscarriages________, births___________
__Menstrual history; started at age_________
stopped at age______, regular______, irregular__
days of flow_____, length of cycle_______,
pains or cramps_______
__First day of period________________
__Last pap smear date________________
normal_________, abnormal__________
__Last mammogram date________________
normal_________, abnormal__________
__Birth control method________________
__Do monthly self breast exams?
__Vaginal discharge/Itching/Dryness/Bleeding after intercourse
__Menopausal symptoms________________

EYES:
__Blurred vision/Double vision
__Cataract/Glaucoma
__Glasses/Contracts

RESPIRATORY:
__Frequent cold ,cough, asthma,wheezing,emphysema
__Shortness of breath
__Pneumonia/Bronchitis

GASTROINTESTINAL:
__Loss of appetite/Difficulty swallowing
__Heartburn/Peptic ulcer
__Frequent nausea/Vomiting/Diarrhea/Constipation
__Belching/Abdominal pain/Stool/Rectal bleeding
__Gall bladder problems/Jaundice/Heptatitis/Chrohn's Disease, Diverticulosis

BLOOD:
__Anemia/Bruise easy/Any blood transfusions
__Sickle cell disease/Hemophilia or bleeding disorder
__Cancer/History of chemo or radiation

MUSCLES AND BONES:
__Pain or stiffness in joint/Muscle weakness
__Back, neck or foot pain
__Gout/Osteoporosis

BREAST:
__Swelling/Redness or Pain
__Lumps in breast/Breast cancer
__Nipple discharge, changes or retractions

PSYCHIATRIC:
__Depression/Anxiety/Nervousness/Agitation/Moody
__Sleep problems
__Memory loss or forgetfulness
__Suicidal ideations/Phobia/Feelings of worthlessness

INFECTIONS:
__Chicken pox/Polio/Measles/Mumps/German measles/Tuberculosis/Herpes

TESTS AND IMMUNIZATIONS

(Give date last done)

	YES	Year Performed	Not Sure	Never	
Pap Smear (Women)					
Breast Exam					
Breast Mammography					
Rectal Exam					
Sodium & Potassium					
Sigmoidoscopy					
Stool for Occult Blood					
Chest X-ray					
EKG					
Chol., Trigl					
Fasting Blood Sugar					
Thyroid Profile					
Tetanus (DPT)					
Flu Shot					
Pneumonia Vaccine					
Hearing Test					
Vision Test					
Genitalia Exam (Male)					
Treadmill Stress Test					
Blood Profile					
Pulmonary Function					
Urine Test					

WOMEN ONLY:

Menstrual
Periods: Age onset_____ Periods regular or irregular________Date last period _______Difficulty w/periods___________

Pregnancies: Number of children born alive ______________
Number of Caesarean sections______________
Number of prematures ______________
Number of stillborns ______________
Miscarriages ______________
Describe any complications ____
____

FRED L. LESLIE, D.O., P.L.
SEMINOLE FAMILY HEALTH CENTER
10875 PARK BLVD., STE C
SEMINOLE, FL 33772
Phone: 727-851-9910
FAX: 727-851-9949

Request for Release of Medical Records For:

Date: ________________

____ ____________________
Patient Name D.O.B.

____
Patient's Signature

Obtain from Dr.____
Physician's Name

____
Address

____
City State Zip

____
Telephone FAX

I hereby request that my medical records be released to:
Fred L. Leslie, D.O., P.L.
Seminole Family Health Center
10875 Park Blvd., Ste. C
Seminole, FL 33772

NOTICE OF PRIVACY PRA[illegible]

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.

This notice takes effect on ______________________ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR DATA BREACH NOTIFICATION PURPOSES: We may use your medical information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information due to a breach.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect [illegible] [illegible]ic Violence: We may use and disclose medical information to appropriate authorities if we [illegible] [illegible]ably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $________ for each page, and postage if you want the copies mailed to you. Additionally, if we maintain an electronic health record containing your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
7. You have the right to restrict information given to your third party payer (e.g., health insurance plan) if you fully paid for your health care services out of your own pocket. If you paid in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.
8. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

____

____

____

____

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.