REGISTRATION FORM: *Please Print*

Complete ALL sections.
Missing information may result in charges billed directly to the patient.

PATIENT INFORMATION - PAGE 1

Last Name:	**First Name:**	M.I.:
Also known as or maiden name:		
Marital Status: ☐ Single ☐ Married	**Date of Birth:**	Age:
Sex: ☐ M ☐ F ☐ Prefer not to specify	**Social Security #:***	
Race: ☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native ☐ Asian ☐ Unknown ☐ Other or Prefer not to specify		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to specify		
Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Punjabi ☐ Hearing Impaired/Sign ☐ Vietnamese ☐ Other ☐ Prefer not to specify		
Preferred Phone #:		☐ Home ☐ Cell ☐ Work
Second Phone #:		☐ Home ☐ Cell ☐ Work
Street Address:		P.O. Box/Apt #:
City:	State:	Zip Code:
E-mail Address:		
Employer:	Phone #:	
Primary Care Physician:	Phone #:	
Did a Physician refer you to this office or did you choose this office yourself? ☐ Physician ☐ Self		
If a Physician, please state who:		
Preferred Pharmacy:	Phone #:	
Pharmacy Location/Cross Streets:		

INJURY INFORMATION - Date of Injury:

Non-Work Related Injury: ☐ Yes ☐ No	Work Related Injury: ☐ Yes ☐ No

IN CASE OF AN EMERGENCY

Emergency Contact:	Relationship to Patient:
Home Phone #:	Work Phone #:

* *University Centers of Excellence's new electronic medical record system (EMR) requires your social security number as your unique identification number. Please help us provide you with the highest quality of care by sharing your social security number. This is very important because without your social security number as an identifier, your electronic medical record may not be complete or may contain inconsistencies. Please be confident your social security number is used only used for this purpose — it is never printed out. It is protected from misuse just as we protect your health information.*

REGISTRATION FORM: *Please Print*

Complete ALL sections.
Missing information may result in charges billed directly to the patient.

Last Name:	First Name:	M.I.:

INSURANCE INFORMATION - *Please give your insurance card to the receptionist.*

Guarantor Information: ☐ ***Check here if same as patient*** Responsible Party:	Date of Birth:
Address (*if different from patient*):	Home Phone #:
Occupation: Employer:	
Employer Address:	Phone #:

PRIMARY INSURANCE - Insurance Company Name:

Subscriber's Name:		Subscriber's SS #:
Date of Birth:	Group #:	Policy #:
Co-pay: $ Patient's relationship to subscriber: ☐ Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other:		

SECONDARY INSURANCE (*IF APPLICABLE*) - Insurance Company Name:

Subscriber's Name:		Subscriber's SS #:
Date of Birth:	Group #:	Policy #:
Patient's relationship to subscriber: ☐ Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other:		
Is this a worker's compensation claim: ☐ Yes ☐ No		

Medicare Secondary Reason Code (Must check one if Medicare is Secondary):

- ☐ 12 **Working Aged** Beneficiary or Spouse with Employer Group Health Plan
- ☐ 13 End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
- ☐ 14 No-fault Insurance including Auto is Primary
- ☐ 15 Worker's Compensation
- ☐ 16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)
- ☐ 41 Black Lung
- ☐ 42 Veteran's Administration
- ☐ 43 **Disabled** Beneficiary Under Age 65 with Large Group Health Plan (LGHP—Employers with 50+ employees)
- ☐ 47 Other Liability Insurance is Primary (Homeowners)

What is your preferred method of communication for appointment reminders?

☐ Phone ☐ Regular Mail ☐ Web Portal ☐ Text Message ☐ Do Not Contact

PRIVACY CLAUSE: A person is liable for constructive invasion of privacy when they attempt to capture, any type of visual image, sound recording, or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than $5,000 and not more than $50,000 [California Civil Code, Section 1708.8].

Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient/Guardian Signature Date

Shared Electronic Medical Records

We share a electronic medical records system with Community Medical Centers.

Smoke Free Environment

For the health of our patients, employees and visitors, smoking is not permitted at the University Centers of Excellence offices.

Weapon Free Environment

Weapons of any kind are not allowed at any of the University Centers of Excellence offices.

No Show/Appointment Cancellation Policy

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "No Show" and a $ 35.00 charge may be billed directly to you since it is not covered by any insurance plan.

I have read, understand, and agree to the above No Show/Appointment Cancellation Policy.

______________________________________ ______________________
Patient Signature (Guarantor if patient is a minor) Date

____
Print Name

Electronic Appointment Reminders

We offer an appointment change notification service via text message to your cell phone (standard text message rates may apply).

___ I want to receive appointment reminders and appointment change notifications via text message

___ I do not want to receive appointment reminders and appointment change notifications via text message

______________________________________ ______________________
Patient Signature (Guarantor if patient is a minor) Date

Agreement and Authorization for Services Consent Form

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to University Centers of Excellence, also known as Central California Faculty Medical Group and University Faculty Associates, that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the University Centers of Excellence medical staff and personnel. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Retention of Information

I understand that University Centers of Excellence may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by University Centers of Excellence for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-University Centers of Excellence personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

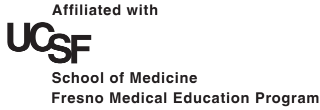
III. Release of Information

I hereby authorize University Centers of Excellence to release to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by University Centers of Excellence and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to University Centers of Excellence. This authorization shall not conflict with any internal University Centers of Excellence policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

IV. Teaching Program

University Centers of Excellence are affiliated with the University of California, San Francisco School of Medicine (UCSF). UCSF is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary healthcare professions, post-graduate fellows and other trainees may observe, examine, treat and participate, at the request and under the supervision of the attending physician in the patient's care, as part of UCSF's medical education programs.

Please see reverse.



Agreement and Authorization for Services Consent Form

V. Assignment of Benefits and Guarantee of Payment

In consideration of University Centers of Excellence and medical services provided to me, I hereby assign University Centers of Excellence and physicians and other professionals associated with University Centers of Excellence all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided.
I agree to pay University Centers of Excellence and the physicians and other professionals associated with University Centers of Excellence the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

I have read each of the foregoing, I-V and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

Patient	Date
Guardian if patient is under 18 years old	Date
Other (record relationship to patient)	Date
Witness	Date

Financial and Billing Policies

Thank you for choosing the physicians at Central California Faculty Medical Group, University Faculty Associates and University Centers of Excellence (UCOE). We are committed to clinical excellence in meeting your health care needs. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department their number is listed in your benefit plan booklet or on your ID card.

Inform Us of Changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and responsibility for the cost of the entire visit.

Bring Your Health Information: Bring your health insurance information to your visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms depending on your visit

Co-Payments, Deductibles and Co-Insurance: Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept cash, checks, debit, VISA, and MasterCard.

Patient Responsibility Balances: All patient responsible balances must be paid in full or a financial arrangement must be made at the time of your visit.

Deposits: For certain procedures, you may be required to pay a deposit or pay for the service in full prior to treatment.

Prompt Payment: We offer a prompt payment discount. Please contact our Billing Department for details.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre existing, or is not a covered service you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained by your appointment you may need to reschedule your visit until you have a current referral. We realize this is an inconvenience, but without the referral our physician will not be reimbursed for the services provided.

Workers Compensation: Please bring your claim number, date of injury and employer/workers compensation information. Your claim needs to be open and valid for the condition that we are seeing you for.

Statements: You will not receive a statement until your primary insurance company has fulfilled its financial responsibility or a service is determined to be patient responsibility.

Please see reverse.

Financial and Billing Policies

Who Can Discuss a Bill: Confidentiality is important. Our Patient Account Representatives may only speak with the patient or the person designated in writing by the patient to receive the bill(s) on behalf of the patient.

Thank you for understanding our billing policies. All billing inquiries are handled by our billing staff. If you should have any questions regarding your bill or the status of your account please contact our office at: 559-453-5231, Monday through Friday 8:00 am – 4:30 pm.

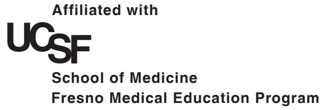
I have read, understand, and agree to the above Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to University Centers of Excellence. I authorize University Centers of Excellence to release pertinent medical information to my insurance company when requested, needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform University Centers of Excellence of any changes regarding my personal billing information or my insurance billing information.

____ ________________________

Patient Signature (Guarantor if patient is a minor) Date

Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.



Acknowledgement of Receipt of Privacy Notice

I have received the University Centers of Excellence Privacy Notice during this visit. I understand that I may obtain a copy of any future revised Notices at any University Centers of Excellence location or on University Centers of Excellence website: www.UniversityMDs.com.

________________________________ ____________________

Patient/ Spouse/Nearest Relative/Legal Guardian Date

To be completed by University Centers of Excellence Employee if acknowledgement is not signed:

Reason that this acknowledgement was not signed:

________ Patient indicates received on prior visit

________ Patient declined to sign

________ Other

________________________________ ____________________

Patient/Representative initials if declined Employee's initials

Personal Representative

In the space below, if so desired, please indicate any personal representatives*/individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact CCFMG in writing and request the change.

Name(s):____

____

________________________________ ____________________

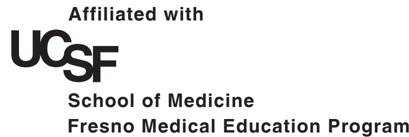
Patient Signature Date

**A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed.*

Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin,age, disability, or sex.

Affiliated with University Faculty Associates

University | Centers of Excellence



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.

If you have any questions about this notice or would like to request further information about our privacy policies and procedures, please contact the Privacy Officer, of our office at:

University Faculty Associates
Central California Faculty Medical Group (CCFMG)
2625 E. Divisadero Street
Fresno, CA 93721
Attention: Privacy Officer
(559) 453-5200

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff, office personnel, and other members of our workforce. The practices described in this notice will also be followed by all healthcare providers with whom you might consult with by telephone (when your regular healthcare provider from our office is not available) and by those who provide "call coverage" for your healthcare provider.

OUR RESPONSIBILITIES AS REQUIRED BY LAW

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information. As part of our obligations, we shall notify affected individuals following a breach of unsecured protected health information. We have the right to change our Notice of Privacy Practices and we will apply the change to your entire protected health information, including information obtained prior to the change. We shall abide by the terms of the Notice of Privacy Practices currently in effect. We shall post a notice of any changes to our Privacy Policy in our office lobby, on our practice website, and make a copy available to you upon request. In circumstances where state or federal law may further restrict the disclosure of your protected health information, we shall follow the more stringent law.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following describes different ways that we may use or disclose your protected health information. For each, we will explain what we mean and provide an example of such use or disclosure. Please be aware that not every use or disclosure in a particular category will be listed. Nevertheless, all of the ways in which we are permitted to use or disclose your protected health information will fall into one of the categories below.

For Treatment. We may use protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to physicians, allied health professionals, technicians, trainees, volunteers, office staff or other personnel who are involved in your healthcare.

For example, your physician may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The physician may use your medical history to decide what treatment is best for you. The physician may also tell another physician about your condition so that physician can help determine the most appropriate care for you.

Different personnel in our office may share protected health information about you and disclose protected health information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment. We may use and disclose protected health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclose protected health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your protected health information to evaluate the performance of our staff in caring for you. We may also use protected health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you.

Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other health care providers who participate in the Exchange and, in other certain limited circumstances, with other health care providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for health care providers to access when it is determined that you require emergent care. You may opt-out of having your health information shared through the Central California Health Information Exchange.

SPECIAL SITUATIONS

We may use or disclose protected health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help or prevent the threat.

Required by Law. We will disclose protected health information about you when required to do so by federal, state or local law.

Research. For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process. This process may include asking for your authorization.

Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release protected health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose protected health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits or Disputes. If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose protected health information about you in response to a subpoena.

Directory Information. We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to member of the clergy. You may request that we not include your name in the directory.

Vaccine Registry. We may use and disclose vaccine information about you or your child to help maintain a regional registry that will assist counties with maintaining continuity and coordination of services.

Law Enforcement. We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors. We may disclose protected health information regarding a deceased person to: (1) coroners and medical examiners to identify cause of death or other duties, (2) funeral directors for their required duties, and (3) to procurement organizations for purposes of organ and tissue donation.

Information Not Individually Identifiable. We may use or disclose protected health information about you in a way that does not individually identify you or that has been de-identified in accordance with applicable federal and state laws and regulations

Fundraising and Marketing. We may contact you with information as part of our fundraising efforts, but you have a right to opt-out of receiving such communication.

Business Associates. There are some services provided to our organization through contracts with business associates, such as billing or transcription services. We may disclose your health information to our business associates so to that they can perform these services. We require the business associates to safeguard your information in a manner consistent with applicable federal and state laws and regulations.

Family and Friends. We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose protected health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your protected health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only protected health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

DISCLOSURES REQUIRING AUTHORIZATION

We will not use or disclose your protected health information for any purpose other than those identified in the previous sections without your specific, written Authorization. The following uses and disclosures will be made only with your authorization: (1) most uses and disclosures of psychotherapy notes, if recorded by a covered entity; (2) uses and disclosures of protected health information for marketing purposes; (3) disclosures that constitute a sale of protected health information; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

If we have highly sensitive protected health information, such as, HIV, substance abuse, or mental health information about you, we cannot release that information without a special signed, written authorization (different from the Authorization mentioned above) from you (i.e. you must specify the type of sensitive information we are allowed to disclose).

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your protected health information that we use to make decisions about your care. Usually these include medical and billing records, but not psychotherapy notes and information compiled for legal proceedings. You must submit a written request to the Privacy Officer, in order to inspect and/or copy your protected health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer.] We will respond to your request for an accounting of disclosures within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) we did not create, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the health information that we keep; (3) you would not be permitted to inspect and copy; or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of protected health information about you, except those disclosures made for: (1) treatment, payment, or healthcare operations; (2) pursuant to a valid authorization; and (3) as otherwise provided in applicable federal and state laws and regulations. To obtain this "accounting of disclosures", you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting in any twelve (12) month period is free of charge. Additional requests for accounting of disclosures may result in charges to you for the costs of providing such accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will respond to your request for an accounting of disclosures within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. If you have paid for services out-of-pocket, in full, and request that we not disclose your protected health information, related solely to those services, to your health plan, we shall accommodate your request except where the disclosure is required by law.

You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to the Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. For example, you can ask that we only contact you at work or only contact you by mail at a specifically identified address. Notwithstanding the foregoing, we will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Privacy Officer.

Right to Revoke Authorization. You have the right to revoke an authorization to use or disclose your protected health information at any time, except where action has already been taken.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer at the address and telephone number listed on the first page of this notice. You will not be retaliated against or penalized for filing a complaint.

The contact information for the Secretary of Health and Human Services is:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 1-877-696-6775

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