Dear Patient,

We understand the trust involved in choosing a medical practitioner to partner with you in reaching your highest level of physical wellness and we are pleased you have chosen Summit Medical Carolinas to be that partner.

We have designed our practice to ensure that each of our patients will receive the highest level of care by bringing our healthcare services directly to you in the comfort of your home.

To allow us to meet your needs and dedicate the quality and quantity of time with you, we request you contact us directly **to schedule all routine or urgent appointments by calling us at 980-443-6788.** Our office hours are **Monday through Friday from 8:00am – 5:00pm**.

For urgent needs after hours, please ask the staff at your community to contact one of our on-call providers.

Included in this packet are some new patient forms that we will need you to complete. There will also be a prompt for uploading advanced directives and Power of Attorney documents at the bottom of this packet.

Paperwork Enclosed

Please complete as thoroughly as possible

- Patient History Form
- Patient Information
- Acknowledgement of Receipt of Notice of Privacy Practices
- Acknowledgement of Change of Primary Care Provider Form
- Authorization of the Use of Disclosure of Protected Health Information
- HIPAA Authorization to Release Protected Health Information
- General Consent and Understanding Form
- Attach a Copy of Advanced Directives and POA/Guardianship Paperwork
- Attach a Copy of Insurance Card and Driver's License or State Identification Card

If you would like to download this packet and complete it by hand, you can return it to our office by having the staff in your community fax it to **980-580-4749** or by mailing to:

Summit Medical Carolinas
9935-D Rea Road, Suite 324
Charlotte, NC 28277

Thank you again for placing your trust in Summit Medical Consultants to bring our expertise and compassionate care to you in your home!

Patient Information

Patient Information

Last Name | *First Name* | *Middle Initial*

Mailing Address

City | *State* | *Zip*

Home Phone | *Cell Phone* | *Work Phone*

Email Address

Sex: ☐ M ☐ F ☐ T

Date of Birth (mm/dd/yyyy)

Social Security Number | *Responsible Party/Guarantor of Insurance Policy*

Insurance Information

Primary Insurance:

Subscriber Name (First/Last) | *Subscriber Date of Birth (mm/dd/yyyy)*

Subscriber Social Security Number | *Relationship to Patient*

ID Number | *Group Number*

Insurance Mailing Address

City | *State* | *Zip* | *Insurance Phone Number*

Secondary Insurance:

Subscriber Name (First/Last) | *Subscriber Date of Birth (mm/dd/yyyy)*

Subscriber Social Security Number | *Relationship to Patient*

ID Number | *Group Number*

Insurance Mailing Address

City | *State* | *Zip* | *Insurance Phone Number*

Tertiary Insurance:

Subscriber Name (First/Last) | *Subscriber Date of Birth (mm/dd/yyyy)*

Subscriber Social Security Number | *Relationship to Patient*

ID Number | *Group Number*

Insurance Mailing Address

City | *State* | *Zip* | *Insurance Phone Number*

Pharmacy*:*

Pharmacy Name

Pharmacy Address

City | *State* | *Zip*

Pharmacy Phone Number | *Pharmacy Fax Number*

Contacts:

Emergency Contact Name

Emergency Contact Home Phone Number | *Emergency Contact Cell Number*

Financial Power of Attorney Name | *Financial Power of Attorney Phone Number*

Medical Power of Attorney Name | *Medical Power of Attorney Phone Number*

Primary Care Provider Name | *Primary Care Provider Phone Number*

Referring Provider Name | *Referring Provider Phone Number*

Demographics:

Marital Status: ☐ Married *(Not Separated)* ☐ Married *(Separated)*

☐ Single ☐ Widowed

☐ Divorced ☐ Domestic Partnership

Primary Language | *Race* | *Ethnicity* | *Employment Status*

Advanced Directive:

Do you have an Advanced Directive? ☐ Yes ☐ No

SUMMIT Medical Carolinas

Patient History Form

Date: _____ Age: _____ Sex: ☐ M ☐ F ☐ T

Name: _____ Date of Birth: _____

Medication Allergies: (*Please list the medication(s) and briefly describe the reaction)*

_____

_____

_____

_____

Other Allergies:

_____

_____

_____

Current Medication(s):

Name of Medication	Dose & Frequency	How long have you been taking this?

Past Medical History: Do you now or have you ever had:

☐ Diabetes	☐ Heart Murmur	☐ Crohn's Disease
☐ High Blood Pressure	☐ Pneumonia	☐ Colitis
☐ High Cholesterol	☐ Pulmonary Embolism	☐ Anemia
☐ Hypothyroidism	☐ Asthma	☐ Jaundice
☐ Goiter	☐ Emphysema	☐ Hepatitis
☐ Cancer: *(List type)* _____		☐ Stroke
☐ Stomach or Peptic Ulcer	☐ Leukemia	☐ Epilepsy (Seizures)
☐ Rheumatic Fever	☐ Psoriasis	☐ Cataracts
☐ Tuberculosis	☐ Angina	☐ Kidney Disease
☐ HIV / AIDS	☐ Heart Problems	☐ Kidney Stones

Other Medical Conditions *(please list)*:

_____

_____

_____

Family History:

		IF LIVING		IF DECEASED
Family Member	**Age**	**Health & Psychiatric**	**Age at Death**	**Cause of Death**
Father				
Mother				
Sibling ☐ Brother ☐ Sister				
Sibling ☐ Brother ☐ Sister				
Child ☐ Son ☐ Daughter				

Child ☐ Son ☐ Daughter				

Social History:

Living Situation:

Marital Status: ☐ Married *(not separated)* ☐ Married *(Separated)*

☐ Single ☐ Widowed

☐ Divorced ☐ Domestic Partnership

Living with: _____

Support System: _____

_____

Tobacco Use / Smoking:

Are you a current or former smoker? ☐ Yes ☐ No

How many packs per day? _____ How many years have you smoked?_____

If a former smoker, when did you quit? _____

Do you use other tobacco products? ☐ Yes ☐ No

If yes, what, and how often? _____

_____

Alcohol/Drug Use:

Do you use any illicit substances? ☐ Yes ☐ No

If yes, what and how often? _____

Do you use any marijuana? ☐ Yes ☐ No If yes, how often? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often did you drink alcoholic drinks in the past year? _____

How many drinks did you have a on a typical day when drinking alcohol in the past year? _____

How often did you have six (6) or more drinks on one (1) occasion in the past year? _____

Other Medical Conditions or Concerns:

Please note any other medical conditions or concerns not previously mentioned above:

_____

_____

_____

_____

Admin Use Only Below

Date patient paperwork scanned and manually entered into Ethizo: _____

General Consent and Understanding

Consent for Care:
I, with my signature, authorize Summit Medical Carolinas, and any designee working under the direction of the physician, to provide medical care for me, or to this patient for which I am guardian. This medical care may include services and supplies related to my health and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and other items required and in accordance with a prescription.

Consent for Release of Information and Assignment of Benefits:
I also authorize Summit Medical Carolinas to provide information to the identified insurance carrier(s) for any and all services they render. I also consent to assign all payments for services rendered directly to Summit Medical Carolinas.

Financial Policy:
Summit Medical Carolinas will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure the financial obligation is fulfilled for the health care services rendered and received.

- I understand and agree that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation.
- I understand and agree that my contract with my insurance entity may or may not cover some services. Summit Medical Carolinas is not responsible or able to know the content of my policy. It is my responsibility to verify applicable coverage prior to receiving services.

I have read and understand this document and content as stated above and agree to accept full responsibility as described above.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

Summit Medical Carolinas
9935-D Rea Road, Suite 324
Annie Peacock, Privacy Officer | 720-990-1417

I hereby acknowledge that I have received a copy of Summit Medical Carolinas' Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted on the company website.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____
Email Address

_____ _____
Print Name Telephone

_____ _____
Signature Date

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

_____
Patient Name

_____
Patient Address

_____
Patient City, State, Zip

Acknowledgement of Change in Primary Care Provider

Summit Medical Carolinas
9935-D Rea Road, Suite 324
Charlotte, NC 28277

I hereby acknowledge that I have requested a change in my primary care provider to the Summit Medical Carolinas provider team.

I would like to receive a copy of this notice by email at: _____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Patient Name: _____

Name of community where the patient resides: _____

Authorization for the Use or Disclosure of Protected Health Information (PHI)

As required by the Health Insurance Portability and Accountability Act of 1996, Summit Medical Consultants may not use or disclose your health information except as provided by our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to our office by:

Mail: Summit Medical Carolinas, 9935-D Rea Road, Suite 324, Charlotte, NC 28277
Fax: 980-580-4749
Email: office@summitmc.org

AUTHORIZATION SECTION

I, _____, hereby authorize the use and disclosure of the following health information that pertains to me:

_____

_____

for the following purposes:

_____

_____

I authorize the following persons to make these disclosures of my health information:

_____

_____

I authorize the following persons to receive these disclosures of my health information:

_____

_____

I understand that information disclosed pursuant to this authorization may be redisclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the Revocation Section of my copy of this form and returning it to Summit Medical Carolinas. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc., will not depend on, in any way, whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____

Signature Date

Authorization for the Use or Disclosure of Protected Health Information (PHI)

As required by the Health Insurance Portability and Accountability Act of 1996, Summit Medical Consultants may not use or disclose your health information except as provided by our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to our office by:

Mail: Summit Medical Carolinas, 9935-D Rea Road, Suite 324, Charlotte, NC 28277
Fax: 980-580-4749
Email: office@summitmc.org

AUTHORIZATION SECTION

I, _____, hereby authorize the use and disclosure of the following health information that pertains to me:

_____

_____

for the following purposes:

_____

_____

I authorize the following persons to make these disclosures of my health information:

_____

_____

I authorize the following persons to receive these disclosures of my health information:

_____

_____

I understand that information disclosed pursuant to this authorization may be redisclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the Revocation Section of my copy of this form and returning it to Summit Medical Carolinas. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc., will not depend on, in any way, whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____

Signature Date

Billing Statement and Disclosure

IMPORTANT NOTICE TO OUR PATIENTS

Patients admitted to this Facility and seen by Summit Medical Carolinas physicians, nurse practitioners, and/or physician assistants will receive a separate billing statement directly from Summit Medical Carolinas for medical services rendered. Summit Medical Carolinas providers are not employed by the Facility and provide separate medical services including but not limited to professional assessment and services, direction and oversight of care.

The services provided by Summit Medical Carolinas are separate, and in addition to the services provided by the Facility. Summit Medical Carolinas will bill Medicare Part B, Medicaid, and most commercial or private insurance for all physician, nurse practitioner and/or physician assistant services provided to you during your stay.

Summit Medical Carolinas will bill you for the portion not covered by Medicare Part B, commercial or private insurance - generally these are for services not covered by your plan or a portion of the charges not covered by your plan such as deductibles and copays.

If you do not have insurance (self-pay) you will be responsible for payment of these services in full and Summit Medical Carolinas will bill you directly.
Please Note: Summit Medical Carolinas does not participate in all insurance plans and is not responsible for obtaining referrals, approvals or authorizations, or for knowing the requirements of your plan or coverage. It is the responsibility of the patient to know, understand and comply with the requirements of their insurance plan or coverage.

If you have any questions about Summit Medical Carolinas or our services, please contact our office at 980-443-6788. Thank you.

SUMMIT Medical Carolinas

Assisted Living Facilities

980-443-6788

OFFICE ADDRESS
Summit Medical Carolinas
9935-D Rea Road, Suite 324
Charlotte, NC 28277

FAX: 980-580-4749

Revised 12/16/2022

NOTICE OF PRIVACY PRACTICES

Summit Medical Carolina (SMC), Annie Peacock and Krishna Kamuni, Privacy Officers

Effective Date: June 1, 2017. Amended December 11, 2018. Amended September 25, 2020. Amended April 21, 2021. Amended July 28, 2021.

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law, to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Official listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in an electronic health record. This is your medical record. The medical record is the property of Summit Medical Carolina, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this

information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, long-term care facilities and other entities which collectively provide health care services.

4. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

5. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

6. **Public Health.** We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury, or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative

promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

7. **Health Oversight Activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by law.

8. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

9. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

10. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

11. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

12. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

13. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

14. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

15. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

16. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the

breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

17. **CORHIO Patient Notification.** Summit Medical Carolina endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO Health Information Exchange, or cancel an opt-out choice, at any time.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we cannot agree and we maintain the record in an electronic format, we will provide your choice of a readable electronic or hardcopy format. We

will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and state law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. **Right to Amend.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. **Right to a Paper or Electronic Copy of this Notice.** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Official listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an

amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Official listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRComplaint@hhs.gov.

For more information on filing a claim, click here.

To file a complaint online, click here.

To file a complaint in writing, open and fill out the Health Information Privacy Complaint Form Package – PDF. You may either:

- Print and mail the completed complaint and consent forms to:
  Centralized Case Management Operations
  U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 209F HHH Bldg.
  Washington, D.C. 20201

- Email the completed complaint and consent forms to OCRComplaint@hhs.gov. *Please note that communication by unencrypted email presents a risk that personally identifiable information contained in such an email, may be intercepted by unauthorized third parties.*

To submit a written complaint in your own format:

- Print and mail the completed complaint and consent forms to:
  Centralized Case Management Operations
  U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 209F HHH Bldg.
  Washington, D.C. 20201

Be sure to include:

- Your name
- Full address
- Telephone numbers (include area code)
- E-mail address (if available)
- Name, full address, and telephone number of the person, agency, or organization you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy or Security Rule

- Brief description of what happened. How, why, and when do you believe your (or someone else's) health information privacy rights were violated, or how the Privacy or Security Rule otherwise was violated
- Any other relevant information
- Your signature and date of complaint

If you are filing a complaint on someone's behalf, also provide the name of the person on whose behalf you are filing.

You may also include:

- If you need special accommodations for us to communicate with you about this complaint
- Contact information for someone who can help us reach you if we cannot reach you directly
- If you have filed your complaint somewhere else and where you've filed

You will not be penalized in any way for filing a complaint