CURE 4 THE KIDS
FOUNDATION

## Welcome to the offices of Cure 4 The Kids Foundation.

We appreciate the confidence and trust that you have placed in our office and look forward to meeting you personally and professionally. Our goal is to provide the highest quality care in a friendly, caring and efficient environment.

We have enclosed our new patient paperwork for your convenience. Please return the completed forms and a copy of your insurance card several days in advance of your office appointment. This will allow our staff the opportunity to process this information into our data system. We hope to provide timely visits and correspondence with your physicians.

**We ask that you bring the following items to our office for your first visit:**

- Current insurance card & driver's license or government issued photo ID
- Recent school report cards and if available, special education documents (IEP or 504 Plan)

Please check in at the **3rd Floor** of our Las Vegas office located at **One Breakthrough Way, Las Vegas, NV 89135** (closest intersection is 215 and Town Center Dr.).

Should you have any questions or need any additional information please don't hesitate to call our office at **702-732-1493.**

We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you.

Sincerely,

**The Staff of Cure 4 The Kids Foundation**

# Patient Registration & Insurance Information

Please verify patient's information and change if incorrect. The front desk is available if you have any questions.

## Patient Information

ALL ITEMS MUST BE COMPLETED – DO NOT LEAVE ANY BLANKS

| PATIENT NUMBER | DATE | SSN | |
|---|---|---|---|
| PATIENT LAST NAME | FIRST NAME | MIDDLE INIT | SUFFIX |
| ADDRESS | CITY | STATE | ZIP |
| HOME TEL # | WORK TEL # | CELL # | SEX / AGE |
| DATE OF BIRTH | EMPLOYER | EMAIL ADDRESS | |
| USUAL PROVIDER | REFERRING PHYSICIAN | PRIMARY CARE PHYSICIAN | |
| MARITAL STATUS | EMPLOYMENT STATUS<br>☐ Full ☐ Part ☐ Retired ☐ Unemployed | STUDENT STATUS<br>☐ Full-Time ☐ Part-Time ☐ Not a Student | |
| RELATIONSHIP TO GUARANTOR | PREFERRED PHARMACY & LOCATION (INTERSECTION) | PREFERRED PHARMACY PHONE # | |

ETHNICITY *(SELECT 1)*
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown/Refused

LANGUAGE
☐ English ☐ Spanish ☐ ______________

RACE *(SELECT 1)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Japanese ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other/Refused

## Insurance Information

INCLUDE ALL INSURANCE COVERAGE INFORMATION INCLUDING MEDICAID OR MEDICARE.

| Primary Insurance | | Secondary Insurance | |
|---|---|---|---|
| CARRIER NAME | | CARRIER NAME | |
| CLAIMS MAILING ADDRESS | | CLAIMS MAILING ADDRESS | |
| MEMBER / ID # | | MEMBER / ID # | |
| GROUP NAME | | GROUP NAME | |
| CLAIM/GROUP NO. | | CLAIM/GROUP NO. | |
| PROVIDER / CLAIMS PHONE # | | PROVIDER / CLAIMS PHONE # | |
| SUBSCRIBER NAME | | SUBSCRIBER NAME | |
| SUBSCRIBER D.O.B. | | SUBSCRIBER D.O.B. | |
| SUBSCRIBER SSN | | SUBSCRIBER SSN | |
| RELATIONSHIP TO PATIENT | | RELATIONSHIP TO PATIENT | |

## Guarantor Information (Person Financially Responsible)

| GUARANTOR LAST NAME | FIRST NAME | MIDDLE INIT | |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |
| HOME TEL # | WORK TEL # | CELL # | EMAIL ADDRESS |

## Emergency Contact Information

| | | | | |
|---|---|---|---|---|
| 1 | EMERGENCY CONTACT #1 | | | SUFFIX |
| | PHONE #1 | PHONE #2 | PHONE #3 | RELATIONSHIP TO PATIENT |
| 2 | EMERGENCY CONTACT #2 | | | SUFFIX |
| | PHONE #1 | PHONE #2 | PHONE #3 | RELATIONSHIP TO PATIENT |

# Patient Health History Questionnaire

Please help us be as efficient as possible with your first visit to our clinic. This health history questionnaire must be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you.

*Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling of your appointment.*

| TODAYS DATE | | DATE OF LAST PHYSICAL EXAM | | ☐ Unknown |
|---|---|---|---|---|

## Mail Order Pharmacy (if applicable)

| NAME | ADDRESS | PHONE | FAX |
|---|---|---|---|

## Reason for visit

| WHAT IS THE MAIN REASON THE PATIENT IS SEEING A DOCTOR TODAY? | |
|---|---|
| ☐ Referred by a hospital or other provider? If so, who? | |

## Past Medical History

HAS PATIENT EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING PROBLEMS?
IF YES, PLEASE EXPLAIN.

| | | Date of Onset | Date of Testing | Comments | Resolved? |
|---|---|---|---|---|---|
| AIDS | ☐ Yes ☐ No | | | | ☐ |
| HIV POSITIVE | ☐ Yes ☐ No | | | | ☐ |
| TUBERCULOSIS | ☐ Yes ☐ No | | | | ☐ |
| ARTHRITIS | ☐ Yes ☐ No | | | | ☐ |
| CANCER | ☐ Yes ☐ No | | | | ☐ |
| INDICATE TYPE(S) | | | | | ☐ |
| DIABETES | ☐ Yes ☐ No | | | | ☐ |
| INSULIN DEP. (TYPE 1) | ☐ Yes ☐ No | | | | ☐ |
| NON-INSULIN DEP. (TYPE 2) | ☐ Yes ☐ No | | | | ☐ |
| GOUT | ☐ Yes ☐ No | | | | ☐ |
| HEART DISEASE | ☐ Yes ☐ No | | | | ☐ |
| INDICATE TYPE(S) | | | | | ☐ |
| HEPATITIS | ☐ Yes ☐ No | | | | ☐ |
| HIGH BLOOD PRESSURE | ☐ Yes ☐ No | | | | ☐ |
| NEUROLOGICAL PROBLEMS | ☐ Yes ☐ No | | | | ☐ |
| RHEUMATIC FEVER | ☐ Yes ☐ No | | | | ☐ |
| SEXUALLY TRANSMITTED DISEASE | ☐ Yes ☐ No | | | | ☐ |
| STOMACH OR INTESTINAL PROBLEMS | ☐ Yes ☐ No | | | | ☐ |
| URINARY TRACT INFECTIONS | ☐ Yes ☐ No | | | | ☐ |
| OTHER | ☐ Yes ☐ No | | | | ☐ |

## Allergies

LIST PATIENT'S ALLERGENS AND ASSOCIATED REACTIONS (E.G. HIVES, RASH, NAUSEA...)

| ☐ No Known Drug Allergies | | | |
|---|---|---|---|
| ☐ No Known Food Allergies | | List other drug, food, environmental allergens and associated reactions | |

| Allergen & Allergic (Y/N) | | Reaction | Allergen & Allergic (Y/N) | | Reaction |
|---|---|---|---|---|---|
| ASPIRIN | ☐ Yes ☐ No | | | ☐ Yes ☐ No | |
| MORPHINE | ☐ Yes ☐ No | | | ☐ Yes ☐ No | |
| PENICILLIN | ☐ Yes ☐ No | | | | |
| SULFA | ☐ Yes ☐ No | | | | |
| LATEX | ☐ Yes ☐ No | | | | |
| ADHESIVE TAPE | ☐ Yes ☐ No | | | | |

## Family History

CHECK IF PATIENT'S BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING.
IF YES, PLEASE SPECIFY.

☐ Family Medical History Unknown

| | Mother | Father | Sister(s) | Brother(s) | Other | Please Mark if Not Present |
|---|---|---|---|---|---|---|
| DATE OF BIRTH (DOB) | | | | | | |
| HEALTH STATE (GOOD, FAIR, POOR) | | | | | | |
| AGE OF DEATH | | | | | | |
| ALCOHOL/DRUG ABUSE | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ASTHMA | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BLEEDING DISORDER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BLOOD CLOT | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CANCER - TYPE: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DEPRESSION | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DIABETES | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EATING DISORDER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HEART DISEASE - TYPE: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HIGH CHOLESTEROL | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| INTESTINAL DISORDER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| KIDNEY DISEASE | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MENTAL ILLNESS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MIGRAINES | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| NEUROLOGICAL DISORDER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| PREMATURE DEATH | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| STROKE | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SUICIDE ATTEMPT | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| THYROID DISEASE | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| OTHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Medications

PLEASE LIST PATIENT'S MEDICATIONS INCLUDING ASPIRIN, VITAMINS, OVER-THE-COUNTER, OR HERBAL MEDICATIONS.

| Medication Name | Dose | Frequency & Reason | Medication Name | Dose | Frequency & Reason |
|---|---|---|---|---|---|
| | | | ASPIRIN | | |
| | | | COUMADIN/WARFARIN | | |
| | | | HORMONES OR BIRTH CONTROL | | |
| | | | HERBAL SUPPLEMENTS | | |
| | | | VITAMINS | | |
| | | | | | |

## Social History of Patient

| | | | |
|---|---|---|---|
| SINGLE PARENT HOUSEHOLD | ☐ Yes ☐ No ☐ Not Applicable | SPLIT CUSTODY? | ☐ Yes ☐ No ☐ Not Applicable |
| WHO LIVES IN HOUSEHOLD WITH CHILD? | ☐ Mother ☐ Father ☐ Siblings ☐ Other ____ | ARE THERE ANY SAFETY CONCERNS IN THE HOUSEHOLD? | ☐ Yes ☐ No |
| LIVES IN | ☐ House ☐ Apartment ☐ Trailer ☐ Other ____ | SMOKERS IN HOUSEHOLD? ☐ Yes ☐ No | CARETAKER SMOKES? ☐ Yes ☐ No |
| SCHOOL? | ☐ Day Care ☐ Preschool ☐ Home School ☐ Traditional School Grade ____ | EXTRA-CURRICULAR ACTIVITIES | ☐ Sports ☐ Arts ☐ Crafts ☐ Other ____ |
| DOES THE PATIENT USE ALCOHOL? | ☐ Yes ☐ No | DOES THE PATIENT USE TOBACCO? | ☐ Yes ☐ No |

## Birth History of Patient

| | | |
|---|---|---|
| PREGNANCY/MEDICAL PROBLEMS | ☐ Yes ☐ No | If yes, please describe ____ |
| DELIVERY | ☐ Normal ☐ Prolonged ☐ Difficult ☐ Vaginal ☐ C/Section ☐ Breech ☐ VBAC ☐ Other ____ | |
| BIRTH | ☐ Full Term ☐ Premature | Number of Weeks ____ |

## Past Surgical History or Hospital Stays for Patient

HISTORY OF ANESTHESIA PROBLEMS? ☐ Yes ☐ No If yes, list type and reactions ____

| Year | Procedure/Illness | Surgeon/Location |
|---|---|---|
| | | |
| | | |
| | | |

## Recent Imaging and Diagnostic Studies for Patient

(CT, X-RAY, ULTRASOUND, MRI, ETC.)

| Year | Type | Body Part | Facility |
|---|---|---|---|
| | CT SCAN | | |
| | X-RAY | | |
| | MRI | | |
| | ULTRASOUND | | |
| | | | |
| | | | |

## Review of Systems

PLEASE TELL US ABOUT THE PATIENT'S CURRENT SYMPTOMS.

| General | | Cardiovascular | | Musculoskeletal | |
|---|---|---|---|---|---|
| NORMAL ACTIVITY LEVEL | ☐ Yes ☐ No | CHEST PAIN | ☐ Yes ☐ No | BACK PAIN | ☐ Yes ☐ No |
| NORMAL APPETITE | ☐ Yes ☐ No | IRREGULAR HEARTBEAT | ☐ Yes ☐ No | JOINT PAIN | ☐ Yes ☐ No |
| NORMAL SLEEP | ☐ Yes ☐ No | PALPITATIONS | ☐ Yes ☐ No | **Neurological** | |
| NORMAL GROWTH/DEVELOPMENT | ☐ Yes ☐ No | SHORTNESS OF BREATH | ☐ Yes ☐ No | FAINTING | ☐ Yes ☐ No |
| NORMAL SPEECH/LANGUAGE | ☐ Yes ☐ No | **Gastrointestinal** | | SERIOUS HEAD INJURIES | ☐ Yes ☐ No |
| **Skin** | | ABDOMINAL PAIN | ☐ Yes ☐ No | SEIZURES | ☐ Yes ☐ No |
| ACNE | ☐ Yes ☐ No | CONSTIPATION | ☐ Yes ☐ No | EPILEPSY | ☐ Yes ☐ No |
| CONCERNING MOLES/BUMPS | ☐ Yes ☐ No | DIARRHEA | ☐ Yes ☐ No | **Psychiatric** | |
| RASH | ☐ Yes ☐ No | VOMITING | ☐ Yes ☐ No | UNCOOPERATIVE/DEFIANT | ☐ Yes ☐ No |
| **Head & Neck (HEENT)** | | **Genitourinary** | | ANXIOUS/DEPRESSED | ☐ Yes ☐ No |
| FREQUENT HEADACHES | ☐ Yes ☐ No | BLOOD IN URINE | ☐ Yes ☐ No | DIFFICULTY WITH TEACHERS | ☐ Yes ☐ No |
| VISION PROBLEMS | ☐ Yes ☐ No | CONCERNS W/BLADDER CONTROL | ☐ Yes ☐ No | DIFFICULTY WITH CHILDREN | ☐ Yes ☐ No |
| HEARING PROBLEMS | ☐ Yes ☐ No | CONCERNS W/BOWEL CONTROL | ☐ Yes ☐ No | **Endocrine/Hematopoietic** | |
| ITCHY, WATERY EYES | ☐ Yes ☐ No | INCONTINENCE | ☐ Yes ☐ No | DIFFICULTY WITH HEAT | ☐ Yes ☐ No |
| STUFFY NOSE | ☐ Yes ☐ No | CONCERNS W/SEXUAL DEVELOPMENT | ☐ Yes ☐ No | DIFFICULTY WITH COLD | ☐ Yes ☐ No |
| NECK PAIN | ☐ Yes ☐ No | SIDE (FLANK) PAIN | ☐ Yes ☐ No | EXCESSIVE THIRST | ☐ Yes ☐ No |
| **Respiratory** | | URINARY COMPLAINTS | ☐ Yes ☐ No | EXCESSIVE URINATION | ☐ Yes ☐ No |
| COUGH | ☐ Yes ☐ No | **Females Only** | | EASY BRUISING | ☐ Yes ☐ No |
| WHEEZING | ☐ Yes ☐ No | MISSED PERIODS | ☐ Yes ☐ No | | |
| | | MENSTRUAL IRREGULARITIES | ☐ Yes ☐ No | | |

## Current Doctors

PLEASE LIST ANY DOCTORS THAT YOU ARE CURRENTLY SEEING AS A PATIENT:

| Doctors Name | Phone Number *(if known)* | Type of Doctor | Condition Being Treated |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# Financial Policy and Assignment of Benefits

**Patient Name:** ______________________________________________ **Date of Birth:** ___________________________

As our patient, we care about you and want to help you understand our billing process.

**IF YOU ARE INSURED**
Cure 4 The Kids Foundation will submit claims to your insurance company. Copays are expected to be paid at the time of service. After the claims are processed by your insurance company, you will receive statement(s) for any patient balances due, including your co-insurance and deductible. If you cannot pay your balance in full, payment arrangements or coverage under our Charity Care program may be possible. To discuss these options, please contact our Patient Account Representative.

**IF YOU ARE NOT INSURED**
If you are not covered by insurance, our staff will provide an estimate of the cost of your care. This estimate will include anticipated charges based on the recommended treatment plan. Please be aware that our estimate may vary from actual treatment cost due to a variety of factors. You are responsible for the full cost of your care. If you cannot pay your balance in full, payment arrangements or coverage under our Charity Care program may be possible. To discuss these options, please contact our Patient Account Representative.

For further understanding of our billing process, please feel free to contact a member of the Billing Department.

## Please initial each line:

____ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to C4K for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services--including major medical benefits, or services provided to me by C4K.

____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to C4K, my insurance carrier, state, federal accreditation agency, or other medical entity. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by C4K. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within C4K.

____ I understand that it is my responsibility to notify C4K of any changes in my health care coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

____ I understand that I am financially responsible to C4K for any charges not covered by health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by C4K and/or my health care insurer, if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical services received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service.

____ I understand that there is a $25.00 charge for all returned checks.

____ I understand that there is a $25.00 charge for all missed or canceled appointments that are not canceled within 24 hours of the scheduled appointment time.

** THIS ACKNOWLEDGMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING **

*By signing this document, I also acknowledge that I have been made aware of C4K's **Notice of Privacy Practices** , as is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights as well as **Understanding our Billing Process.** I have read and, if requested, received a copy of the above statement and Privacy Practices and accept the terms. A duplicate or facsimile transmission of this statement is considered the same as original.*

**Signature of Insured/Parent/Guardian:** ____________________________________ **Date Signed:** _____/_____/______

**Print Name of Insured/Parent/Guardian:** ______________________________________________________________

## Authorization of Treatment and Disclosure of Medical Information

**Patient Name:** ________________________________________________ **Date of Birth:** ____________________________

I authorize **Cure 4 The Kids Foundation** to treat myself or my child as needed and not hold them responsible for any decisions made in an emergency situation.

No medical information with any third parties will be discussed, unless written consent/authorization has been obtained. This includes discussion by telephone, facsimile, letter, email or in person. This consent form gives C4K permission to discuss medical information for the purpose of administering health care related activities. I hereby agree that Protected Health Information (PHI) may be released by C4K as stated in our clinic's ***Notice of Privacy Practices.***

**I authorize *only* the following individual(s) to accompany minor child/patient to appointments and receive Protected Health Information (PHI) concerning the above named minor child/patient (act as "personal representative(s)" or loco parent is for the above named minor child/patient), in accordance with NRS 129.030 - 129.040:**

Printed Name: ____________________________________________ Relationship to Patient: ________________________

Printed Name: ____________________________________________ Relationship to Patient: ________________________

*I further certify that I am the legal parent/guardian of the above named minor child/patient.*

**Signature of Insured/Parent/Guardian:** ______________________________________ **Date Signed:** _____/_____/_______

**Print Name of Insured/Parent/Guardian:** ____________________________________________________________________

**Employee Witness:** ________________________________________

## Authorization to Release Patient Medical Records

**Patient Name:** ______________________________________________ **Date of Birth:** ___________________________

**Release Information to:**

**Cure 4 The Kids Foundation**
**One Breakthrough Way**
**Las Vegas, NV 89135**
**Phone: (702) 732-1493**
**Fax: (702) 732-1080**

**Release:**

☐ All Records ☐ Labs/Radiology ☐ Notes

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Cure 4 The Kids Foundation (C4K) in writing. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Nevada privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

**Printed Name of Person Requesting:** __________________________ **Phone Number: (_____) _____ - ________**

**Relationship to Patient:** ☐ **Patient** ☐ **Parent** ☐ **Guardian** ☐ **Other** _____________________________

**Authorizing Signature:** __________________________________________ **Date Signed: _____/_____/_______**

### This Authorization Is Valid for One Year From the Date Signed

**Unless I Specify Another Date: ____/____/_____**

# Cure 4 The Kids Foundation has adopted the following privacy practices.

## Notice of Privacy Practices:

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

Cure 4 The Kids Foundation must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement, We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

**1. TREATMENT:** For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.
**2. PAYMENT:** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.
**3. HEALTH CARE OPERATIONS:** We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.
In addition, we may want to use your health information for appointment reminders. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder letter to help you remember the appointment. Alternatively, we may look at your medical information and decide that another treatment or a new service we offer may interest you. For example, we may contact a cancer patient to notify them that we have a new cancer research facility that offers new life-saving treatments.
Furthermore, we may want to use information found in your medical record, such as your name, address, phone number, and treatment dates, to contact you for our fundraising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation.
**4. AS REQUIRED OR PERMITTED BY LAW:** Sometimes we must report some of your health information to legal, authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.
**5. FOR PUBLIC HEALTH ACTIVITIES:** We may be required to report your health information to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.
**6. FOR HEALTH OVERSIGHT ACTIVITIES:** We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.
**7. FOR ACTIVITIES RELATED TO DEATH:** We may disclose your health information to coroners, medical examiners, and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.
**8. FOR ORGAN, EYE, OR TISSUE DONATION:** We may disclose your health information to people involved with obtaining, storing, or transplanting organs, eyes or tissue of cadavers for donation purposes.
**9. FOR RESEARCH:** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.
**10. TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY:** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.
**11. FOR MILITARY, NATIONAL SECURITY, OR INCARCERATION/LAW ENFORCEMENT CUSTODY:** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.
**12. FOR WORKERS' COMPENSATION:** We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.
**13. TO THOSE INVOLVED WITH YOUR CARE OR PAYMENT OF YOUR CARE:** If people such as family members, relatives, or close friends are helping care for you or helping you pay your medical bills, we may release important health information about you to those people. The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information so you can decide whether to object to release of your health information to others involved with your care.
NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information. If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to our administrative staff.

## Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact a member of our administration. Specifically you have the right to:

**1. INSPECT AND COPY YOUR HEALTH INFORMATION:** With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.

**2. REQUEST TO CORRECT YOUR HEALTH INFORMATION:** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

**3. REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES:** You have the right ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Alter natively, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However we are not required to agree in all circumstances to your requested restriction.

If you receive certain medical devices (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the medical device.

**4. AS APPLICABLE RECEIVE CONFIDENTIAL COMMUNICATION OF HEALTH INFORMATION:** You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

**5. RECEIVE A RECORD OF DISCLOSURES OF YOUR HEALTH INFORMATION:** In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

**6. OBTAIN A PAPER COPY OF THIS NOTICE:** Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.

**7. COMPLAIN:** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact a member of our administration, who will provide you with the necessary assistance and paperwork.

A patient/client may call, write, or present in person to a member of the administrative staff or designated person the alleged privacy violation or complaint.

A written response will be provided to the patient/ client within 30 days from the date the complaint was filed.

Translators, interpreters, and others who may help meet any special communication needs of the patient/client may be provided during the complaint process.

Patients/Clients are permitted to have a representative of their choice to represent their interests during the complaint process.

Patients/clients who request an outside agency to review their complaint may contact the Secretary of the Federal Department of Health and Human Services at 200 Independence Ave., S.W.; Washington, DC 20201, or reach the Secretary by phone at (202) 690-7000.

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Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact a member of the administrative staff at our office.

Patient Name: ______________________________ Date: ____________

Patient or Parent/Legal Guardian Signature: ______________________________ Date: ____________

Witness: ______________________________ Date: ____________