WELCOME TO OUR OFFICE

Lawrenceville Foot & Ankle Specialists

Spruha Magodia, DPM
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Board Certified Foot & Ankle Physicians & Surgeons
www.LawrencevilleFAS.com

Patient Information Form

2633 Main Street, Suite 202
Lawrenceville, NJ 08648
315 Broad St
Florence, NJ 08518
Phone: (609) 512-1126 Fax: (609) 512-1639
LawrencevilleFAS@gmail.com

PATIENT INFORMATION:

First Name * _____ Middle Name _____ Last Name* _____

Date of Birth * _____ Age (years) _____ Sex ○ Female ○ Male

Social Security # _____ Email _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone # * _____ May we leave message?* ○ Yes ○ No

Cell Phone # * _____ May we leave message?* ○ Yes ○ No

Work Phone # _____ May we leave message? ○ Yes ○ No

Emergency Contact * _____ Relationship* _____ Phone # * _____

Primary Care Doctor * _____ City & State* _____ Phone # * _____

Have you seen a Podiatrist before?* ○ Yes ○ No

If yes, whom, when and for what condition? * _____

Whom may we thank for referring you to this office? _____

How did you find out about our office? *
- ☐ Physician
- ☐ Family Member
- ☐ Friend
- ☐ Internet
- ☐ Other

I have received and understand the HIPAA information: * _____

Signature

INSURANCE & PHARMACY INFORMATION:

Name of Primary Insurance * _____ ID# * _____ Group# * _____

Name of Secondary Insurance * _____ ID# * _____ Group# * _____

Details of Insurance Card Holder, Parent info if the patient is a minor, or person responsible for account:

Subscriber/Responsible Party Insured Name _____ Date of Birth _____

Patient Relationship _____ Social Security # _____

PREFERRED PHARMACY:

Pharmacy _____ City _____ State _____ Zip Code _____

Phone # _____ Fax # _____

SOCIAL HISTORY:

Marital Status: *
- Single
- Married
- Separated
- Divorced
- Widowed
- Decline to specify

Race: *
- American Indian
- Asian
- Black/African American*
- Hispanic
- White
- Other
- Decline to specify

Ethnicity: *
- Hispanic or Latino
- Not Hispanic or Latino
- Decline to specify

Exercise:
- Never
- Rarely
- Occasionally
- Weekly
- Daily

Employer:

Occupation:

Primary Language:

Type of Current Exercise(s):

Alcohol Use:
- Never
- No Longer Use
- History of Alcohol Abuse
- Socially

Tobacco Use:
- Never
- Yes
- Quit

If Quit, how long ago?

Smoke:
- Never
- Quit
- Yes

If Yes, how many packs/day?

Recreational Drug Use:
- Never
- Quit

If Quit, how long ago?

If Quit, specify type:

Patient Height: *

Patient Weight: *

Recent Blood Pressure: *

Below 90/60 (Low)

CURRENT CONDITION/COMPLAINT:

What brings you to our office today? *

Have you ever seen a podiatrist before for this problem? Yes No

How long ago did this problem start?* Days Weeks Months Years

Did your problem:* Begin all of a sudden Gradually develop over time

Since pain or problem began, has it:* Stayed the same Become Worse Improved

How would you describe your pain?*
- No Pain
- Sharp
- Dull
- Achy
- Burning
- Radiating
- Itching
- Stabbing
- Other (please specify below)

How would you rate your pain? *
- 1 (minimal pain)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (worst pain possible)

What makes your problem feel worse? *
- Daily Activities
- Elevation
- Standing
- Walking
- Resting
- Running
- Touching/Rubbing
- At Night
- Putting Pressure
- Bending Toes
- Wearing Certain Shoes (please specify the type below)
- Other (please specify below)

What makes your problem feel better?

What treatments have you had for this problem?

How has this problem affected your lifestyle or ability to work?

Was this problem caused by an injury or accident? * Yes No

Vein Screening Questionnaire:

Do you experience aching, heaviness or leg pain or leg cramps?	Do you have swollen legs, feet, or ankles?	Do you have itchy or skin discoloration?	Do you have visibly swollen veins?
○ Yes	○ Yes	○ Yes	○ Yes
○ No	○ No	○ No	○ No

REVIEW OF SYSTEMS:

Check-mark all that you experience currently:

Cardiovascular: *
- ☐ Chest Pain
- ☐ Fainting
- ☐ Heart Palpitation
- ☐ Lower Extremity Swelling
- ☐ Shortness of Breath
- ☐ None

Constitutional: *
- ☐ Chills
- ☐ Fatigue
- ☐ Fevers
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Sweats
- ☐ Vomiting
- ☐ Weight Loss
- ☐ None

EENT: *
- ☐ Blurred or Double Vision
- ☐ Cataracts
- ☐ Congestion
- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Earaches
- ☐ Ears Ringing
- ☐ Eye Pain or Irritation Eye
- ☐ Discharge
- ☐ Failing Vision
- ☐ Frequent Nose Bleeds
- ☐ Frequent Sore Throat
- ☐ Prolonged Hoarseness
- ☐ Sensitivity to Light
- ☐ Sinus
- ☐ None

Endocrine: *
- ☐ Cold Intolerance
- ☐ Excessive Appetite
- ☐ Excessive Thirst & Urination
- ☐ Heat Intolerance
- ☐ Weight Changes
- ☐ None

GI: *
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stool Changes
- ☐ None

Lymphatic: *
- ☐ Excessive Bleeding
- ☐ Excessive Bruising
- ☐ Swollen Glands
- ☐ None

Musculoskeletal: *
- ☐ Arthritic
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling Muscle
- ☐ Cramping Muscle
- ☐ Stiffness Muscle
- ☐ Weakness
- ☐ None

Neurologic: *
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness
- ☐ Paralysis (partial or complete)
- ☐ Seizures
- ☐ Tingling
- ☐ Tremors
- ☐ Unsteady Gait
- ☐ Weakness
- ☐ None

Respiratory: *
- ☐ Chronic Cough
- ☐ Chronic Wheezing
- ☐ Coughing Up Blood
- ☐ Excessive Phlegm
- ☐ Shortness of Breath
- ☐ None

Skin: *
- ☐ Dry Skin
- ☐ Itching
- ☐ Rash
- ☐ Skin Changes
- ☐ Suspicious moles
- ☐ Other abnormalities (list these below)
- ☐ None

If Other, specify:

Urological: *
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Unusual Discharge
- ☐ None

Vascular: *
- ☐ Bleeding or Clotting Disorders
- ☐ Easy Bruising
- ☐ Leg or Calf Pain
- ☐ Night Cramps
- ☐ Rest Pain
- ☐ Swelling
- ☐ None

FAMILY'S MEDICAL HISTORY:

Family Member's Medical History (Select ALL applicable to each family member category): *

	Mother	Father	Brother	Sister	Others
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension Stroke	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐
Other (Specify below)	☐	☐	☐	☐	☐
None	☐	☐	☐	☐	☐

If 'Other' selected for any member above, please specify details:

MEDICAL HISTORY:

Check-mark (select) each of the items applicable to you. Do you have or ever had any of the below previously? *

☐ Abnormal Bleeding	☐ Blood Transfusion	☐ Heart Disease	☐ Neuropathy	☐ Stomach Ulcer
☐ Acid Reflux	☐ Bronchitis/Emphysema	☐ Hepatitis	☐ Numbness	☐ Stroke
☐ Anemia	☐ Cancer	☐ High BP	☐ Open Sores	☐ Thyroid Disease
☐ Arthritis	☐ Diabetes	☐ HIV/AIDS	☐ Parkinson's	☐ Tingling
☐ Asthma	☐ Dialysis	☐ Kidney Disease	☐ Pneumonia	☐ Tuberculosis
☐ Back Pain	☐ Fibromyalgia	☐ Liver Disease	☐ Sciatica	
☐ Bladder Infections	☐ Gout	☐ Low BP	☐ Sickle Cell	
☐ Blood Clots	☐ Heart Attack	☐ Migraines	☐ Skin Disorder	

Any other conditions?

ALLERGIES :

Types of allergies you may have:

Medical *	○ Yes	○ No
Seasonal *	○ Yes	○ No
Iodine *	○ Yes	○ No
Local Anesthesia *	○ Yes	○ No
Food Allergies *	○ Yes	○ No
Other *	○ Yes	○ No

If Yes to any, please list details about each allergies: *

MEDICATION HISTORY:

Please list all medications you are currently taking (Including Prescriptions, Over the Counter Meds and Herbal Supplements):

Name of Medication:	Dose Detail & How Often:	Reason:

Pneumonia Vaccination:* ○ Yes ○ No If Yes, provide Month & Year: _____

Flu Vaccine:* ○ Yes ○ No If Yes, provide Month & Year: _____

Covid-19 Vaccine:* ○ Yes ○ No If Yes, provide Month & Year: _____ # of shots taken: _____

SURGICAL HISTORY:

Have you had any prior surgeries or been hospitalized for any reason? * ○ Yes ○ No

If Yes, please list all prior surgeries or hospitalizations you have had and when you had them:*

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Insured/Guardian Signature: _____ If Guardian, Relationship to Patient: _____ Date: _____

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Legal Assignment Of Benefits And Designation Of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

Signature of Insured / Guardian: _____ Date: _____

FINANCIAL POLICY

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Commercial/Indemnity Subscribers:

For Office Services:

Payment is expected as services are rendered unless prior financial arrangements have been made. A receipt will be provided for you which can also be used for submission to any secondary insurance or health care accounts you may have.

For Surgical Services:

Our office will submit surgical fees to your health insurance carrier.

HMO & PPO Patients:

It is ***impossible*** for the staff to know everything about your health insurance coverage; they are often tailored to suit the needs of the employer. If you require a referral, ***you*** are responsible for obtaining one ***prior*** to your visit. If you require a referral, and are seen by the physician without one, ***you*** will be responsible for any charges. Please read the information booklet provided to you by your health insurance carrier.

In order to submit charges for services rendered, you will need to provide a referral from your primary physician, if required, copies of your health insurance and identification cards. Copay, if you have one, is required for each visit.

Medicare & Medicare HMO Patients:

We are participating providers for Medicare, therefore, you are responsible only for deductibles and the 20% co-insurance. If your primary or secondary health insurance carrier is an HMO, you will need to provide referrals from your primary physician. We will need copies of your health insurance identification cards.

Cancellation Policy:

As a courtesy and in order to accommodate all our patients, we ask that you give 24 hour notice for cancellation or rescheduling of an appointment.

A **$35 fee** will be charged for failure to comply with this request for regularly scheduled appointments. A **$50 fee** will be charged for an orthotic cast that is missed.

Durable Medical Equipment:

Please be advised that insurance companies have been giving out misinformation regarding ***all*** durable medical equipment including the following: Orthotics, Braces, Splints, etc…

Please assume that unless you have a written document from your insurance company, you are financially responsible for the device.

Although our office may file insurance forms, you understand that it is your responsibility to ensure that you are covered for the services rendered. If your insurance company does not pay such bills, for any reason, you understand and agree that you are liable for the payment in full.

Any bill not paid within thirty (30) days after it is sent, shall be charged an administrative fee of **$5** per month on the outstanding balance until paid or financial arrangements are made. In the event it becomes necessary for us to send the claim to collections, there will be an additional administrative charge of **$50.**

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You realize that non covered services will be billed directly to you as well as deductibles, co-insurance amounts.
3. You attest to the accuracy and completeness of the medical insurance coverage information given.
4. You authorize this office to release medical information necessary to process your claims and appeals.
5. You authorize payment of medical benefits to our office.
6. There is a returned check fee of $35.00
7. You understand that having insurance does not guarantee payment.

Patient/Responsible Party: Name & Signature: _____ Date: _____

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HIPAA Release Form

Patient Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information.

This information may be released to:

- ☐ Spouse: * Name & Phone #: _____
- ☐ Child(ren): * Name & Phone #: _____
- ☐ Other: * Name & Phone #: _____
- ☐ Information is not to be released to anyone *

Messages:

Please Call

- ☐ My Home * Phone #: _____
- ☐ My Work * Phone #: _____
- ☐ My Cell * Phone #: _____

If unable to reach me: *
- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call
- ○ do not leave a message

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

HIPAA 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.

About This Notice

This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

How We May Use and Disclose Your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

For Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

For Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for hospital admission.

For Health Care Operations
We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

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

Fundraising Activities
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

Plan Sponsors
If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

Facility Directories
Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people

that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Business Associates
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

For Data Breach Notification Purposes
We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan, if applicable, through which you receive coverage.

Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

Your Rights Regarding Health Information About You

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

This office is not required to agree to a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket. If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to receive notice of a security breach. We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Complaints or Questions

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. You may reach our office by calling: **(609) 512-1126**

If you have a question about this privacy notice, please contact our Privacy Officer at: **(609) 512-1126**

Effective Date: This notice is effective as of 9/23/2013.

Name & Signature **Date**

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