You are scheduled to see Dr. Joseph Russell at __________________ on _____________________

Location: North Area, 7555Northside Dr., N. Charleston, SC 29420 | East Cooper, 900 Bowman Rd. Ste. 201, Mt. Pleasant, SC 29464 | West Ashley, 1470 Tobias Gadson Blvd., Charleston, SC 29407

(First)	(Middle Initial)	(Last)
Date of Birth:	Age:	S e x:
Address:	City:	State: Zip:
Home Phone #:	Work Phone #:	Cell #:
S.S.#:	Driver's License #:	Marital Status:
Race:	Ethnicity:	Language:
Email Address :		
Employed By :		
Address :		
Spouse/Parent:	Driver's License #:	
D.O.B.:	S.S. #:	
Employed by:	Work Phone:	
Primary Care Physician:	Phone:	
Referring Doctor:	Phone:	
Pharmacy Name, Address and Telephone Number:		

PRIMARY INSURANCE INFORMATION	
Ins. Company Name:	Effective Date:
Insured:	Insured's SS #:
Insured Address:	
Insured Phone #:	Insured D. O. B.:
Policy No:	Group No:
SECONDARY INSURANCE INFORMATION	
Ins. Company Name:	Effective Date:
Insured:	Insured's SS#:
Insured Address:	
Insured Phone #:	Insured D. O. B.:
Policy No:	Group No:

I authorize the release of any medical information necessary to process any insurance claims and access to Pharmacy records. I also authorize payments of medical benefits NATIONAL ALLERGY & ENT. I understand that I am financially responsible for all charges not covered by my insurance, irrespective of the amount of insurance coverage. I understand that my insurance coverage may not cover all of my medical charges, and that I am responsible for any and all billing and/or collection fees.

_________________________________ _______________

Signature of Patient or Responsible Party (if a minor) Date

_________________________________ _______________

Signature of Witness Date

NATIONAL
ALLERGY & ENT
National Experts, World-Class Care

Patient Name: ______________________________ DOB:__________ Date:__________

What is the reason you are here today? ______________________________

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: ____________

ALLERGIES? ☐ **No Allergies**

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or

☐ **No Current Medications**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)______________________________

Preferred Lab: (circle one or indicate 'other') Quest Labcorp Other____________

***MEDICAL / SURGICAL HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Medical / Surgical History**

Cardiovascular:	**Yes**	**Surgery/Management**
Coronary Artery Disease	☐	__________
Elevated Cholesterol (hyperlipidemia)	☐	__________
High Blood Pressure (hypertension)	☐	__________
Gastrointestinal:		
Hepatitis	☐	__________
Hernia	☐	__________
Gastroesophageal Reflux	☐	__________
Genitourinary:		
Prostate enlargement (Benign Prostate Hyperplasia)	☐	__________
Kidney Stones (Nephrolithiasis)	☐	__________
Renal Failure (Acute)	☐	__________
Ear / Nose / Throat: (HEENT)		
Cataracts	☐	__________
Glaucoma	☐	__________
Chronic Ear Infections (Otitis Media)	☐	__________
Hearing Loss	☐	__________
Sinus Problems (chronic sinusitis)	☐	__________
Nasal Polyps	☐	__________
Nasal Allergies	☐	__________
Recurrent Tonsillitis	☐	__________
Tinnitus	☐	__________
Vertigo	☐	__________
Hematologic :		
Anemia	☐	__________
Immunologic:	Yes	**Surgery/Management**
Allergies Type: ________	☐	__________
Food Allergies Type: ________	☐	__________
Infectious Disease:		
Mononucleosis	☐	__________
STD Type: ____________	☐	__________
Metabolic/endocrine:		
Diabetes Type: __________	☐	__________
Thyroid deficiency (hypothyroidism)	☐	__________
Thyroid excess (hyperthyroidism)	☐	__________
Neoplastic:		
Cancer Type: ____________	☐	__________
Neurologic:		
Migraine	☐	__________
Obstetric:		
Pregnancy Date(s): ________	☐	__________
Psychiatric:		
Adjustment Disorder - Anxiety	☐	__________

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Major Depression ☐ ________________

Pulmonary:

Asthma ☐ ________________

COPD ☐ ________________

Emphysema ☐ ________________

Sleep Apnea ☐ ________________

Tuberculosis ☐ ________________

If YES to any of the above Diagnosis was surgery performed?

What________________ **Where/When**____ **By Who**____________________

<u>FAMILY HISTORY of</u>:

		Who
ADD/ADHD	☐	
Alcoholism	☐	
Allergies	☐	
Alzheimer's Disease	☐	
Asthma	☐	
Blood disease	☐	
CAD (Coronary Artery Disease)	☐	
CAD-Premature	☐	
Cancer Type: ____________	☐	

		Who
CVA (Stroke)	☐	
Depression	☐	
Developmental delay	☐	
Diabetes	☐	
Eczema	☐	
Hearing deficiency	☐	
Hyperlipidemia	☐	
Hypertension	☐	
Irritable Bowel Syndrome	☐	

		Who
Learning disability	☐	
Mental illness	☐	
Migraines	☐	
Obesity	☐	
Osteoarthritis	☐	
Osteoporosis	☐	
PVD	☐	
Renal disease	☐	
Seizure disorder	☐	

Other Family History: ____

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ **Yes** ☐ **No**

Caffeine Consumption? ☐ **Yes** ☐ **No** **Type:** ________________________ **Amount per day?** __________

<u>REVIEW OF SYSTEMS</u>: Please mark where applicable:

General health problems

No Yes
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night sweats
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain

Eye problems

No Yes
- ☐ ☐ Double vision
- ☐ ☐ Itchy eyes
- ☐ ☐ Redness

Ear problems

No Yes
- ☐ ☐ Drainage
- ☐ ☐ Hearing loss
- ☐ ☐ Infections
- ☐ ☐ Dizziness
- ☐ ☐ Itchiness
- ☐ ☐ Exposure to Excessive Noise
- ☐ ☐ Ear pain
- ☐ ☐ Ringing /noise in ears

Nose & Sinus problems

No Yes
- ☐ ☐ Congestion
- ☐ ☐ Facial Pain
- ☐ ☐ Mouth Breathing
- ☐ ☐ Nose Bleeds
- ☐ ☐ Sneezing
- ☐ ☐ Runny Nose
- ☐ ☐ Post Nasal Drainage

Prefe

Mouth & Throat problems

No Yes
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Sleep Apnea
- ☐ ☐ Snoring
- ☐ ☐ Sore Throat
- ☐ ☐ Hoarseness
- ☐ ☐ Sores/Ulcers in Mouth

Heart or circulation problems

No Yes
- ☐ ☐ Heart Murmur
- ☐ ☐ Chest pain
- ☐ ☐ Swelling of Ankles/Edema
- ☐ ☐ Blacking Out
- ☐ ☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems

No Yes
- ☐ ☐ Cough
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing

Musculoskeletal:

No Yes
- ☐ ☐ Leg pain

Stomach problems

No Yes
- ☐ ☐ Abdominal Pain
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

Brain or Nervous system problems

No Yes
- ☐ ☐ Headache

☐ ☐Seizures
☐ ☐Focal Weakness
☐ ☐Numbness

Glands & Hormone problems
No Yes
☐ ☐Heat Intolerance
☐ ☐Cold Intolerance
☐ ☐Neck Enlargement/Goiter

Blood or Lymph nodes problems
No Yes
☐ ☐Easy Bleeding
☐ ☐Easy Bruising

Allergy problems
No Yes
☐ ☐Food Allergies
☐ ☐Bee Sting Allergies

☐ ☐Environmental Allergies
☐ ☐Urticaria / Hives

Skin
No Yes
☐ ☐Itchy Skin/ Pruritis
☐ ☐Rash
☐ ☐Contact Allergy

Patient Name: ______________________________ **DOB:** ________________

Responsible Party Signature: ______________________________ **Date:** ________________

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your physician may need to perform certain in-office procedures which enable that diagnosis to be made.

If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. As per the rules of your insurance carrier, you will be responsible for covering any deductible payment.

The physicians of National Allergy & ENT follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, and Videostroboscopy.

☐ By checking this box, you are acknowledging that you have read the above

______________________________ ________________
Signature Date

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. We want to work with you to manage the financial responsibilities you incur as our patient. The following information explains our financial policy:

- Unless other arrangements have been made in advance by either you or your health coverage carrier, **full payment is due at the time of service.** For your
  convenience, we will accept VISA, Mastercard, American Express, Discover or debit card.
- Your insurance policy is a contract between you and your insurance company; the doctor is not involved. Failure to supply our office with current insurance cards and personal information may result in you being responsible for the visit and/or fees **We cannot waive any co-pay, co-insurance or deductible due to healthcare fraud laws.**
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the physician. In other words, you agree to have your insurance company pay the physician directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We can bill those plans with whom we have an agreement and can only require you to pay the authorized co-payment at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- By signing this agreement, you understand the amount of coverage provided by your insurance for these services and agree to cover the remaining balance.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be ***"not covered"***, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call at least 24 hours prior to your appointment if you know you will need to reschedule your appointment. There will be a $50 charge if the appointment is not cancelled in the appropriate amount of time or if the patient is a "no show".
- We charge $35.00 for checks returned for insufficient funds.
- If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment to ensure we have received the referral. It is also your responsibility to keep track of your authorization and make sure you have one each time you see the doctor to receive allergy injections. If the referral is not in hand at the time of service the appointment must be rescheduled.
- We require a physician visit to complete any forms for school, work, etc.
- Your physician may require an office visit in order to process a prior authorization for medication.
- At the physician's discretion, a physician may bill for a "physician to patient" phone call.
- If **full** payment is not made at the time of service you will be referred to an outside collection agency. You will be responsible for all reasonable collection fees.
- You agree, in order for us to service your account or to collect any amounts you may owe, we as well as our third party debt collector may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We as well as our third party debt collector may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- I agree that I will be responsible for all attorney costs and court fees required to settle my account. This agreement is governed by the laws of the SC.
- ***I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to-time by the practice. If you have any questions about the policy, please discuss them with our Administrator.***

By signing, you understand you will be responsible for any remaining balance.

Signature of Patient or Responsible Party (if a minor): ____Date: ________________________

Signature of Co-Responsible Party: ____ Date: ________________________

Printed Name of Patient: ____

I voluntarily consent to medical treatment and diagnostic procedures provided by National Allergy & ENT and its associated physicians, clinicians and other personnel. I consent to the testing for infectious diseases. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read or have had read to me this consent and understand and agree to its contents.

____
Initials

Authorization for Release of Information and Assignment of Insurance Benefits:
My physician is authorized to release any medical information required in the processing of applications and submission of information for financial coverage. I also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries - I provided all necessary information for proper assignment of Medicare/Medicaid benefits.

____
Initials

Agreement of Financial Responsibility:
I guarantee payment of all charges associated with services received from National Allery & ENT. I agree to assign any insurance benefits or other funding to National Allergy & ENT. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain all authorization as required by my health plan prior to the patient's visit.

____
Initials

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification:
I acknowledge my receipt of a copy of the National Allergy & ENT's Notice of Privacy Practices.

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility can only be revoked upon written notice. By signing below, I acknowledge that this consent form has been read in full and explained as necessary.

I authorize National Allergy & ENT physician's and staff to contact me via mail, by phone, or cell phone. If I am unavailable, the physicians or staff may leave messages for me with person or machine at the phone number I have provided.

____
Initials

______________________	____________________________________
Date and Time	Signature of Patient (Parent or Legal Guardian)
______________________	____________________________________
Signature of Witness	Signature of Guarantor (if different from the patient)

I, ________________________________, do hereby authorize a representative from National Allergy & ENT to speak with the following person(s) regarding my: **(please check all the apply)**

Name	Relationship	Phone Number	Medical Care	Appointments

Do you give the above representative(s) authorization to the following information:

☐ I do ☐ I do **NOT** Authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), sexually transmitted diseases, psychiatric care, psychological assessment and treatment for alcohol and / or drug abuse.

☐ I do NOT wish for any medical information/appointments to be released to any representative on my behalf.

I do I do **NOT** Authorize National Allergy & ENT to communicate my protected health information or billing information to me via voicemail.

______________________________ ______________
Signature of Patient or Responsible Party (if a minor) Date

______________________________ ______________
Signature of Patient of Witness Date

This form will be valid until patient rescinds authorization in writing.

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at National Allergy & ENT as well as other health care providers involved in your care and may include sensitive information. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

By signing this consent form, you are agreeing that your provider at National Allergy & ENT may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to National Allergy & ENT to enroll me in this ePrescribe Program.

________________________________Print Patient Name ______________ Patient DOB

________________________________Signature of Patient or Guardian ______________Today's Date

________________________________Relationship to Patient

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain in effect until it is amended or replaced by us. We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and /or received by us before the date changes were made. You may request a copy of our privacy Notice at any time by contacting our Privacy officer, Amber Murphy.
Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes: **Treatment:** While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, Business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by federal law to protect your health information. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.
Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so, as of march 26, 2003 immunization records for students may be released without an authorizations (as long as the PHI disclosed is limited to proof of immunizations). If an individual is deceased you may disclose PHI to a written authorization. Genetic information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.
Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act. allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $0.65 for each page and the staff time charged will be $15. Please contact our Privacy Officer for an explanation of our fee structure.
Right to Request Restriction of PHI: if you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, the Omnibus Rule restricts provider’s refusal of an individual’s request not to disclose PHI.
Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of an emergency involving your care, your location, your general condition or death. If at all possible we will provide you the opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/ or supplies unless you have advised us otherwise.
Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safely or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/ infection exposure and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose or raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and

treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). “Sale of PHI” does not include disclosures for Public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is “a reasonable cost-based fee” to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of “sale”.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) we will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested will be $0.65 for each page and the staff time charged will be $15. If you want the Copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: it is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any others steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.