Nova Wellness Center
CLINIC & MEDSPA

119 West Parkwood Ave, Friendswood, TX 77546
Office (281)542-7800, Fax (281)542-7731
Website: NovaWellnessCenter.com

PATIENT REGISTRATION & CONSENT PACKET **Completed on:_____ (date)**

Patient's First Name:	Middle Initial:
Patient's Last Name:	Date of Birth:
Patient's Mailing Address (street):	
City:	State: Zip code:
How long as the patient lived at the above address?	
If less than 12 months please provide the previous town, state and zip code below*	
City:	***State:*** ***Zip code:***
Patient's Mobile Phone:	Work Phone:
Home or Other Phone:	
Patient's Personal Email Address	
Patient's Work Email Address:	
Sex: ☐ Male ☐ Female	Age:
Social Security #:	
Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed	
Spouse or Partner's Name:	
Employer's Name:	
Patient's Job Title:	
Preferred Pharmacy Name:	Phone Number:
Pharmacy Address:	Zip Code:
Mother's Maiden Name:	
(This will be used as a security passcode for the patient's medical information)	

PERSONS AUTHORIZED TO RECEIVE INFORMATION: (OPTIONAL)

The patient authorizes the following person(s) to receive information regarding their medical condition and/or billing information:

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

PERSONS TO NOTIFY IN CASE OF EMERGENCY: **MUST LIST AT LEAST ONE PERSON**

(1) Name:	Relationship to Patient:
Mobile Phone:	Work Phone:
(2) Name:	Relationship to Patient:
Mobile Phone:	Work Phone:
(3) Name:	Relationship to Patient:
Mobile Phone:	Work Phone:

COMPLETE THIS SECTION ONLY IF THE PATIENT IS A MINOR:

Parent or Guardian's Name:			
Mailing Address (street): ☐ same as patient			
City:		State:	Zip:
Mobile Phone:	Work Phone:		
Personal Email:	Work Email:		
Relationship to the Patient:			
Parents Marital Status: ☐ Married	☐ Living Together	☐ Separated	☐ Divorced
Patient's school:	Current grade level:		

AUTHORIZATION TO RELAY MEDICAL INFORMATION:

In addition to regular mail I, the patient or authorized representative, give permission to Nova Wellness Center staff to communicate patient medical information in the following manner(s).

✓ **CHECK ALL METHODS AUTHORIZED:** ✓ ✓

	Call patient's mobile phone	Okay to leave a voice message	YES		NO	
	sign the "SMS opt in" permisson at end of this packet	Okay to send a text message	YES		NO	
	Call patient's work phone	Okay to leave a voice message	YES		NO	
	Send email to patient's personal email					
	Send email to patient's work email					

***** We do NOT recommend using your work email to transmit information unless you are comfortable with your employer or co-workers having access to information contained in your emails. Employers have access to and maintain control of company email accounts.***

Nova Wellness Center
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ACKNOWLEDGEMENT OF OFFICE POLICIES: **Check all after reading****

☐ I have been provided with a summary of patient rights and protections under **federal health information privacy law (HIPAA).** Our privacy policy handout is included at the end of this packet and is posted on our website NovaWellnessCenter.com for review.

☐ I understand that **Dr. Sachdev or any employees do not contract with any commercial insurance companies, Medicare, Medicaid, Tricare or CHIPs** they are **out of network providers**. Patients are responsible for paying for their care at the time service is rendered**. Nova Wellness Center does not file insurance claims for patients;** however, patients may request a detailed invoice to submit to their insurance company to seek reimbursement or credit applied towards their **out of network deductible.**

☐ **I understand that Dr. Sachdev and her office staff do NOT take phone calls after hours and do not provide care for patients in the hospital.** If patients need evaluation or assistance from a healthcare provider outside of office hours they should go to an emergency room, urgent care facility or retail pharmacy clinic as is appropriate for the severity of the situation. **In the event of an emergency patients, or those responsible for them, should dial "911" immediately.** If patients have questions or concerns about their medications or have run out of medication when the office is closed they should **consult with their pharmacist**. A pharmacist is authorized to dispense a 72 hour supply of chronic medications that are not schedule II controlled substances without requiring permission from the prescribing physician.

☐ I understand that Nova Wellness Center charges **$50 for missed appointments** or cancellations with less than 24 hours' notice. Patients who make a habit of missing their appointments may be discharged from the clinic provider's care.

NOTICE CONCERNING COMPLAINTS
Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information please visit www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS
Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura yasistentes de cirugía. Si necesita ayuda para presentar una queja, llame al:1-800-201-9353. Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us

Please list all chronic or recent medical conditions that you have:

✖		AGE	NOTES
	High blood pressure		
	Congestive heart failure		
	Abnormal heart rhythm		
	Coronary artery disease		
	Cardiomyopathy		
	Congenital heart defect		
	Heart valve disease or defects		
	Renal (kidney) disease or insufficiency		
	Chronic Obstructive Pulmonary Disease (COPD) or Emphysema		
	Asthma		
	Seizure disorder or Epilepsy		
	Chronic headaches		
	Diabetes		
	Pre-diabetes or insulin resistance		
	High cholesterol or triglycerides		
	Chronic heartburn or gastroesophageal reflux (GERD)		
	Food intolerance or sensitivity		
	Peptic ulcer disease		
	Irritable bowel syndrome		
	Inflammatory bowel disorder (Chrons disease or ulcerative colitis)		
	Depression		
	Anxiety		
	Panic disorder		
	Bipolar disorder		
	Attention deficit disorder (ADD or ADHD)		
	Chronic insomnia or shift work sleep disorder		
	Sleep Apnea		
	Chronic or recurrent anemia		
	Restless Legs Disorder		
	Hemoglobinopathy (ex- Thalessemia, Sickle Cell, G6PD deficiency)		
	Fibromyalgia		
	Benign Prostate Enlargement		
	Erectile Dysfunction		
	Thyroid disorder (of any kind)		
	Cancer (of any kind)		
	Chronic or recurrent pain (of any kind)		
	Immune deficiency (of any kind)		
	Seasonal or environmental allergies		
	OTHER:		
	OTHER:		

Please list all past surgeries that you have had:

✖		YEAR	AGE
	Amputation (details):		
	Heart bypass (CABG)		
	Pacemaker insertion or replacement		
	Tonsillectomy		
	Adenoidectomy		
	Pressure equalization tubes in ears (T-Tubes)		
	Sinus surgery		
	Stent placement (location):		
	Caesarean Section (C-sec) how many times?		
	Thyroid surgery (details):		
	Weight loss surgery (details):		
	Heart valve replacement (details):		
	Prostate surgery (details):		
	Vasectomy		
	Tubal ligation (BTL)		
	Removal of uterus (Hysterectomy):		
	Removal of ovary (details):		
	Bladder suspension		
	Hemorrhoidectomy		
	Removal of appendix (Appendectomy)		
	Cataract removal (details):		
	LASIK eye surgery		
	Hernia repair (details):		
	Cervical surgery (details):		
	Gall bladder removal (Cholecystectomy)		
	Liver surgery (details):		
	Removal of spleen (Splenectomy) reason:		
	Kidney surgery (details):		
	Colon surgery (details):		
	Breast surgery (details):		
	Cosmetic surgery (details):		
	Cosmetic surgery (details):		
	Cervical spine (neck) surgery (details):		
	Lumbar spine (low back)surgery (details):		
	Shoulder surgery (details):		
	Elbow surgery (details):		
	Wrist or hand surgery (details):		
	Hip surgery (details):		
	Knee surgery (details):		
	Ankle or foot surgery (details):		

FAMILY HEALTH HISTORY

DIAGNOSIS	LIST AFFECTED FAMILY MEMBERS
High blood pressure	
Congestive heart failure	
Abnormal heart rhythm	
Coronary artery disease	
Cardiomyopathy	
Heart valve disease or defects	
Renal (kidney) disease or insufficiency	
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	
Asthma	
Seizure disorder or Epilepsy	
Chronic headaches	
Diabetes	
Pre-diabetes or insulin resistance	
High cholesterol or triglycerides	
Chronic heartburn or gastroesophageal reflux (GERD)	
Food intolerance or sensitivity	
Inflammatory bowel disorder (Chrons disease or ulcerative colitis)	
Depression	
Anxiety	
Panic disorder	
Bipolar disorder	
Attention deficit disorder (ADD or ADHD)	
Schizophrenia	
Sleep Apnea	
Anemia	
Hemoglobinopathy (ex- Thalassemia, Sickle Cell, G6PD deficiency)	
Fibromyalgia	
Thyroid disorder (of any kind)	
Cancer (of any kind)	
Immune deficiency (of any kind)	
Seasonal or environmental allergies	
OTHER:	
OTHER:	
OTHER:	
ADDITIONAL NOTES:	

	Other surgeries or additional information (list below):	YEAR	AGE

Any history of serious injuries? (Explain below):

List any hospital stays for reasons OTHER than childbirth or surgery?

For FEMALE patients only:

Are you currently pregnant? _____ Past # of pregnancies: _____ Past # of births: _____

Menstrual problems: heavy bleeding _____, cramping _____, irregular frequency _____

Current method of birth control: _____

Age at onset of menses: _____ Age at onset of menopause: _____

Current method of hormone replacement therapy: _____

Last mammogram: _____ Facility: _____ Normal? _____

Last pap smear: _____ Any history of abnormal paps? _____

Last bone density exam: _____ Any abnormal findings? _____

For MALE and FEMALE patients:

Last colonoscopy: _____ (year) Findings: _____

Other colon cancer screening (details): _____

Please list all other medical providers that you are currently seeing, or who you see on a regular basis (doctor's name, location, phone #, specialty, reason seeing, frequency for visits, last visit, and next visit):

Please list all of the over the counter (OTC) medications that you take regularly, or frequently, and the reason that you take them:

Please list all prescription medications that you are currently taking:

Medication	Dose	Instructions	Diagnosis	Prescribing Doctor

Medication(s) you are ALLERGIC to or DO NOT TOLERATE due to side effects:

Please list all nutritional supplements that you are currently taking:

Name	Dose	Instructions	Reason for taking

Describe your current exercise regimen:

Do you experience any problems sleeping? (explain):

Are you on any special diet? (explain):

Please list any nicotine products that you currently use:

How often do you consume alcohol? (type, amount, frequency):

List caffeinated products that you use regularly (type, amount, frequency):

****Complete this form ONLY if you have Medicare coverage****

Lisa Sachdev, DO
Nova Wellness Center

MEDICARE PRIVATE CONTRACT:

Please be advised that Dr. Lisa Sachdev has opted OUT of participation with Medicare. Patients who have any coverage under Medicare (whether Medicare is the primary or secondary coverage) must sign a *Private Contract* before they can be seen by Dr. Sachdev. This is mandated by federal law and is not at the discretion of the physician and/or patient. If you have Medicare coverage (are 65 years of age or older) the providers at Nova Wellness Center will not be able to see you unless this contract is signed.

Per CMS Guidelines the contract requires that a Medicare patient be informed of the following items before they are seen by a physician who has opted out of Medicare:

(Please read and initial each item to confirm your understanding and acceptance of each term)

☐ **The beneficiary, or the beneficiary's legal representative accepts full responsibility for payment of Dr Sachdev** or her staff. This applies to any service provided by Dr. Sachdev or any of her employees.

☐ The beneficiary, or the beneficiary's legal representative, understands that **Medicare limits DO NOT apply to what Dr. Sachdev may charge for items or services provided at or by Nova Wellness Center.**

☐ **The beneficiary, or the beneficiary's legal representative, agrees NOT to submit a claim to Medicare or to** request that Dr. Sachdev **or her office staff submit a claim to Medicare for service or items she provides.**

☐ The beneficiary, or the beneficiary's legal representative, enters into this contract with the knowledge that **the beneficiary has the right to obtain Medicare covered items and services from physicians and practitioners who have NOT opted out of Medicare.** The beneficiary is not compelled to enter into a private contracts that apply to other Medicare- covered services furnished by other physicians or practitioners who have not opted out of Medicare participation.

☐ The beneficiary, or the beneficiary's legal representative, understands that **Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.**

This contract has NOT been entered into during a time when the beneficiary requires emergency or urgent care services. A photocopy of this contract has been provided before items or services were furnished to the beneficiary under the terms of the contract. This contract will be retained by Nova Wellness Center for the duration of the opt-out period.

Patient's Name:_____ DOB:_____

Patient, or authorized agent's, signature:_____

Healthcare provider's signature: Lisa Sachdev, D.O._____

Complete this form ONLY if the patient is a minor

CONSENT TO TREATMENT OF A MINOR

Date:_____

Patient Name:_____ DOB:_____

In my absence, I _____, authorize Lisa Sachdev, D.O., and the staff of Nova Wellness Center to evaluate and treat _____, a minor child, that in their judgment, the physician and/or her staff determine is advisable for my child's well-being. ***My consent remains in effect until such time that it is revoked in writing.***

Please try to contact us regarding the healthcare of my child at the following number(s):

Parent Name:_____ Phone:_____

Parent Name:_____ Phone:_____

Other:_____Relationship:_____Phone:_____

Parent or Guardian Name:_____

Relationship to Patient:_____

Parent or Guardian Signature:_____Date:_____

Note: *If any special parental or custodial relationship exists (such as if the child has one parent only, or if legal custody is held by guardians in the absence of both parents), please explain the situation, along with your signature, printed name, and a contact phone number.*

Explanation:

Telemedicine Informed Consent Nova Wellness Center

Texas Medical Association
Physicians Caring for Texans

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting NOVA WELLNESS CENTER at 281-542-7800.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
NOT REQUIRED	
_____	_____
Witness Signature	Date

The Texas Medical Association acknowledges the Texas Medical Association Special Funds Foundation for its support of this document through funds awarded by The Physicians Foundation.

THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association

Telemedicine Informed Consent

Texas Medical Association
Physicians Caring for Texans

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information, please visit our website at

www.tmb.state.tx.us.

The Texas Medical Association acknowledges the Texas Medical Association Special Funds Foundation for its support of this document through funds awarded by The Physicians Foundation.

THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association

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119 West Parkwood Ave.
Friendswood, TX 77546

Office: (281) 542-7800, Fax: (281)542-7731

EMAIL CONSENT AND GUIDE TO EMAIL USE

As a supplement to your in-office appointments, I am inviting you to use email to communicate with my practice. Set forth below are policies outlining when and how email should be utilized to maintain your privacy and to enhance communication as well as a place for you to acknowledge your consent to its use. Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time. Email will be accessed by Dr. Sachdev or a staff member. You may expect any required response within 3 business days.

When may I use email to communicate with the staff of Nova Wellness Center?
Email may be used to:

- Prescription refill requests
- Appointment requests
- Other matters not requiring an immediate response

When should I NOT use email to communicate with the staff at Nova Wellness Center?
Email should never be used:

- In an emergency
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- If you need an immediate response

What are the advantages to using email?

- Unlike trading voicemail messages, email allows you to see exactly the question the doctor is responding to and to have a written record of that exchange for future reference.
- Email allows for the rapid transmission of forms or other paperwork such as information regarding your medications/condition.

What are the risks of using email?
Risks of communicating via email include but are not limited to:

- Email may be seen by unintended viewers if addressed incorrectly
- Email may be intercepted by hackers and redistributed
- Someone posing as you could access your information.
- Email can be used to spread computer viruses
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters

- Emails are discoverable in litigation and may be used as evidence in court.
- Emails can be circulated and stored by unintended recipients
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment.
- There may be an unanticipated time delay between messages being sent and received.

What happens to my messages?

- Emails will be printed out and maintained as a permanent part of your medical record
- As part of your permanent record, they will be released along with the rest of the record upon your authorization or when the doctor is otherwise legally required to do so.
- Messages may be seen by staff for the purpose of filing or carrying out requests (e.g., appointment scheduling) or when our healthcare providers are away from the office.

What are my obligations?

- I must let the staff of Nova Wellness Center know immediately if my email address changes.
- If I do not receive a response from the staff in the time frame indicated (3 business days),

I will contact him/her by telephone if a response is needed.

- I will use email communication only for the purposes stated above.
- I will advise the staff of Nova Wellness Center in writing should I decide that I would prefer not to continue communicating via email.
- I understand that email may only be used to supplement my appointments with the healthcare providers at Nova Wellness Center and not as a substitute for them.
- To avoid possible confusion, I will not use internet slang or short-hand when communicating via email.

What steps has the staff of Nova Wellness Center taken to protect the privacy of my email communications?

Our staff:

- Set up a password protected screen-saver on his computer
- Educated staff on the appropriate use and protection of email
- Does not access patient email from public Wi-Fi hotspots
- Does not allow family members access to his personal work computer
- Will not transmit highly sensitive information via email
- Will not forward patient email to third-parties without your express consent
- Will verify email addresses before sending messages

What steps can I take to protect my privacy?

- Do not use your work computer to communicate with the staff of Nova Wellness Center as **your employer has a right to inspect emails sent through the company's system**.
- Do not use a shared email account to transmit messages.
- Log out of your email account if you will be away from your computer.
- Carefully check the address before hitting "send" to ensure that you are sending your message to the intended receiver.

- Avoid writing or reading emails on a mobile device in a public place.
- Avoid accessing email on a public Wi-Fi hotspot.
- Make certain that your email is signed with your first and last name and include your telephone number and date of birth to avoid possible mix up with patients with same or similar names.

CONSENT TO EMAIL USE:

By signing below, I consent to the use of email communication between myself/_____ (name of patient) and the staff of Nova Wellness Center. I recognize that there are risks to its use, and despite the staff's best efforts, we cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in the form. I further agree to follow these policies and agree that should I fail do so, the staff of Nova Wellness Center may cease to allow me to use email to communicate with our office staff. I also understand that I may withdraw my consent to communicate via email at any time by notifying the staff of Nova Wellness Center in writing.

_____ _____

Name of Patient/Guardian Date

_____ _____

Signature of Patient/Guardian Email Address

CONSENT TO RECEIVE SMS TEXT MESSAGES: *updated 02/23/2023*

You agree to receive (you "opt in" to receiving) SMS text messages from our organization related to services that we are providing to you. Message and data rates may apply, and message frequency varies.

You may text us STOP at any time to opt out of receiving SMS text messages from us.

You may text us HELP at any time to receive help.

_____ (_____)_____-_____

Signature of Patient/Guardian Mobile Phone Number

Nova Wellness Center
CLINIC & MEDSPA

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.