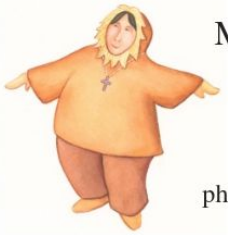
Alaska Bariatric Center



Michael A. Todd, MD, FACS
Deborah A. Warner, MD

1200 Airport Heights Dr. Ste 278
Anchorage, AK, 99508
phone (907)929-4263 fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

WELCOME to Alaska Bariatric Center. Thank you for choosing us for your weight loss journey.

Location: Alaska Regional Hospital Building E, 1200 Airport Heights Road Suite 278, Anchorage, AK 99508.

Office Hours: 8:00am-5:00pm Monday through Friday, phones are forwarded to answering service at 4:30pm.

Closed on: New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Holiday, and Christmas Holiday.

Dr. Michael Todd and his professional staff will do their best to provide you with exceptional healthcare, quality administrative and billing support as well as provide answers to any questions or concerns you may have. As we begin our medical and business relationship, we would like to inform you of some important details about our office.

Please check out our website at www.alaskabariatriccenter.com along with our Facebook page at www.facebook.com/alaskabariatriccenter. We also have an affiliated website of www.obesityhelp.com, and the ASMBS website at www.asbs.org for additional information on Bariatric surgery

See below for instructions regarding your upcoming orientation:

Generally speaking, these are the steps that occur during your Orientation Day:

We ASK that you arrive by:

ALL PATIENTS- 7:30 AM

We will start your process by completing some preoperative testing. Some tests require you to be fasting. Please drink plenty of water the day before Orientation. No food or beverages, including water, after midnight the night before orientation.

Orientation can be an all-day event. We encourage you to bring snacks and lunch.

A $50 non-refundable, non-billable fee will be required prior to your Orientation to reserve your spot.

We require our intake paperwork to be completed and returned at **minimum three days** prior to your scheduled Orientation. Should we not receive the enclosed intake packet **at least three days before** your orientation, we will reschedule you to our next available orientation. Included is a pre-paid return envelope for your convenience.

Please be prepared to present the following at the time of your appointment:

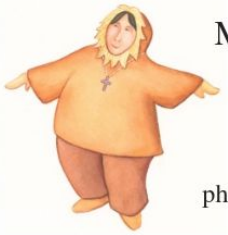
- Driver's license or other state issued photo identification.
- All insurance cards, including Medicare and/or Medicaid card.
- A complete list of your medications.

After Orientation, we offer a Support Group Meeting from 12:00-1:00pm. There will also be an evening Support Group Meeting from 5:00-6:00pm. Both of these Support Group Meetings will be held in our office. We typically offer Support Group Meetings every Wednesday from 12:00-1:00pm and 5:00-6:00pm and every Friday from 12:00-1:00pm. Please check our schedules for any updates. It is a requirement that you attend a minimum of 3 Support Group Meetings prior to surgery as part of your preparation process.

As a general surgeon, and a specialist in bariatric surgery, Dr. Todd may be called out of the office at any given time. **Orientation and Initial appointments are subject to change.** We request that you please be patient and courteous to our staff should your appointments be delayed, or rescheduled. Please keep in mind that you shall receive the same priority services should you ever require emergency medical attention while under Dr. Todd's care. We appreciate your patience, diligence and again, thank you for choosing Alaska Bariatric Center. We look forward to serving you and being a part of your healthcare journey.

Sincerely,
Dr. Todd and the Alaska Bariatric Center Team

Alaska Bariatric Center



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PATIENT INFORMATION FORM

PATIENT INFORMATION

NAME – LAST: _____ FIRST: _____ M.I.: ____

DATE OF BIRTH: _____ SEX: (circle one) M F SOCIAL SECURITY NUMBER: _____

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

PARENT/GUARDIAN/SPOUSE

RELATIONSHIP TO PATIENT_____

NAME – LAST: _____ FIRST: _____ M.I.: ____

DATE OF BIRTH: _____ SEX: (circle one) M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____ SOCIAL SECURITY NUMBER: _____

PRIMARY MEDICAL INSURANCE

Date of Accident/Injury:_____ CARDS SCANNED_____

_____
(Primary Insurance Company Name) (ID#) (Group#)

_____
(Policy Holder Name) (INSURED Date of Birth)

SECONDARY MEDICAL INSURANCE

CARDS SCANNED_____

_____
(Secondary Insurance Company Name) (ID#) (Group#)

_____
(Policy Holder Name) (INSURED Date of Birth)

EMERGENCY CONTACT INFORMATION

_____
(Name) (Phone) (Relationship)

_____
(Name) (Phone) (Relationship)

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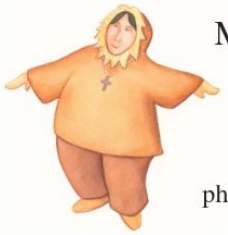

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AGREEMENT FORMS

- May we leave you a detailed message:
  At home? YES NO *Initial*_____ Cell? YES NO *Initial*_____
- May we use your pictures and generic patient information for the following reasons; medical conventions *and/or* conferences, discussions regarding issues at Bariatric Support Group meetings, use in insurance appeals.
  YES NO *Initial* _____
- May we post your picture on the website (alaskabariatriccenter.com)? YES NO *Initial* _____
- May we show your picture *and/or* video's including pre and post-surgical weight at the ABC Annual Gala?
  YES NO *Initial* ____
- May Dr. Todd and other staff members include your patient information in text messages regarding your care with our office or other providers? YES NO *Initial* _____

Date Signed: _____Patient Printed Name: _____Signature of Patient: _____

NOTICE OF SOCIAL MEDIA POLICY

I, the undersigned am aware that any contact with Alaska Bariatric Center and its staff may be documented and included in my medical records. This includes but is not limited to; emails, text messages, and all other forms of social media.

Signature of Responsible Party: _____Date:_____

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible part also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payer.

Signature of Responsible Party: _____Date:_____

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office, and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

Signature of Responsible Party: _____Date:_____

AKNOWLEDGEMENT OF EMERGENT CARE PRIORITY POLICY (DR. TODD PATIENTS)

As a general surgeon, and a specialist in bariatric surgery, Dr. Todd may be called out of the office at any given time. We request that you please be patient and courteous to our staff should your appointment be delayed, or rescheduled. Please bear in mind that you shall receive the same priority in service should you ever require emergent medical attention while under Dr. Todd's care.

Signature of Responsible Party: _____Date:_____

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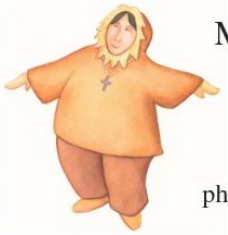

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1.) Alaska Bariatric may disclose my health information to: _____
Relationship: _____

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

2.) Alaska Bariatric may disclose my health information to: _____
Relationship: _____

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

SURGERY PAYMENT AGREEMENT

At your last appointment prior to surgery known as your pick up orders you are required to pay 20% of your copay or coinsurance. We will call your insurance once again to verify how much of your out of pocket has been met to calculate the 20% needed to pay.

_____ _____
Patient Name (please print) Print Name of Parent/Responsible Party (if applicable)

_____ ____/____/____
Signature of Patient/Parent/Responsible Party Date

HIPAA AGREEMENT FORM

Please read and sign below:
The pages accompanying this receipt are our *Notice of Privacy Practices,* which provides a detailed description of what we do with health and personal information that we have about you. It also explains your rights, as a patient, for getting access to that information and controlling its use and disclosure.
Per HIPAA regulations, we are required to ask you to sign this *Acknowledgement of Receipt of Notices of Privacy Practices.* You have the right to refuse our request, in which case, we must document your refusal for the record.
Sign your acknowledgement below for having received our *Notice of Privacy Practices* and then return this page to our staff.
Thank You!
Patient's acknowledgement of receiving notice of Privacy Practices
I acknowledge that I was provided my personal copy of my health care provider's *Notice of Privacy Practices* to read and keep as my own.

_____ _____ ____/____/_____
Patient Name (please print) Signature of Patient (or Responsible Party) Date

____/____/_____ _____-_____-_____
Patient's Date of Birth Patient's Social Security Number

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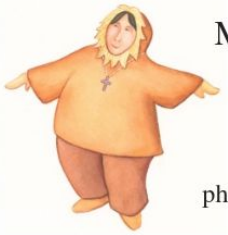

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BILLING FORMS

NOTIFICATION OF NON-COVERAGE OR POSSIBLE NON-COVERAGE

- Telephone Assessment (98966) ex: *Telephone Touchbase*
  - Charge- $55.00
    - Tricare- not covered
    - Medicare- not covered
    - Medicaid- not covered
    - Private- specific to your individual plan
- Medical Nutritional Therapy (97802-97804) ex: *Dietary Evaluation*
  - Charge- $280.00
    - Tricare- not covered as available on base
    - Medicare- ONLY covered if you have Diabetes or Renal Failure
    - Medicaid- ONLY covered if you are under 21 or pregnant
    - Private- specific to your individual plan
- Homocysteine Lab (83090)
  - Charge- $204.00
- Insurance Lifetime Maximum
  - It is possible for a covered procedure to have a lifetime maximum payable amount. In these cases, the patient is responsible for the remaining balance. We encourage patients to verify with their insurance company for coverage and benefits to avoid unforeseen patient expenses.
- Usual and Customary
  - Insurance companies have set allowable amount. If a patient's insurance company is not contracted with our office, the patient is responsible for any difference between insurance allowable and charges accrued.

PLEASE SIGN BELOW AFTER READING THE ABOVE INFORMATION. YOUR SIGNATURE ACKNOWLEDGES THAT YOU ARE AWARE THAT THESE SERVICES MAY OR MAY NOT BE COVERED BY YOUR INSURANCE AND THAT YOU ARE RESPONSIBLE FOR PAYMENT.

Signature: _____ Date:_____

Printed Name: _____

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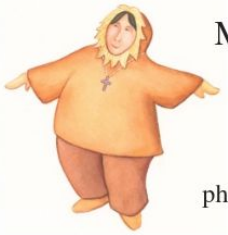

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PATIENT NOTICE OF BILLING PRACTICES

PLEASE READ, INITIAL WHERE INDICATED, AND SIGN BELOW.

Payments for medical services provided by Alaska Bariatric Center is due at the time of service. We accept cash, most credit cards, personal checks, and money orders. Payment **in full** at time of service is required when:

- You do not have insurance coverage
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A referral or prior authorization was not obtained.
- Any procedures or treatments we believe are not covered by insurance.

Patient responsibility:

(Initial)

____ Insurance coverage is not a guarantee of payment.

____ We will bill your insurance company as a courtesy, if you present your insurance card(s) at the time of your appointment.

____ Any co-payments or "patient responsibility" must be paid at the time of service.

____ Any remaining balance, after all applicable insurance payments have been applied, is due upon receipt of billing statement.

____ **Prior to receiving a surgery date, your account balance must be paid in full.**

____ If payment in full is not received within 90 days from the date of the first statement, your account may be turned over to cornerstone credit services.

____ Cancelled appointments require 24 hours' notice; otherwise they will be subject to a $25 charge.

____ If we do not receive response from your insurance company within 45 days from the date we bill them, then the balance will become **patient responsibility.**

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons may include, but are not limited to:

- Your deductible has not been met.
- You have not received the proper referral or preauthorization for the visit or procedure.
- The services or procedures are not covered by your insurance company. ***We will inform you when we know a treatment/procedure will not be covered. Some insurance policies have exclusions for bariatric surgery. If there is any uncertainty about coverage, we would be happy to provide you with an estimate of your fees prior to treatment. You are responsible for all non-covered services at the time of your visit.***

We may choose to use an independent laboratory. If so, this lab will bill separately for these services. We will provide your insurance information to the lab so that they may file a claim with your carrier. The lab will then bill you for any remaining balance. You will need to contact them directly for any questions regarding their bill. This also applies to any other testing we may order for you that is performed by another provider.

By signing my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them

Signature: _____ Date: _____

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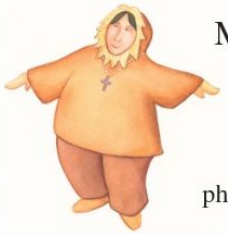

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MEDICAL HISTORY QUESTIONNAIRE

By filling out this very detailed personal questionnaire, we can cut down the time you have to spend in our office. This information will also help us to take better care of you.

PERSONAL INFORMATION

Full Name (First, Middle, Last): _____

I was referred by: _____

What is your occupation? _____

Are you married? Y or N Do you have children? Y or N *If so, how many? _____

Who do you live with? _____

Do you decline blood products? Y or N If yes, please explain:

_____

INFORMATION ABOUT YOUR OTHER HEALTHCARE PROVIDERS

My regular doctor is Dr. _____

Specialty: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____Fax: _____E-mail: (optional):_____

Second doctor/therapist to send a report to is Dr._____

Specialty: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____Fax: _____E-mail: (optional):_____

Third doctor/therapist to send a report to is Dr._____

Specialty: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____Fax: _____E-mail: (optional):_____

PERSONAL WEIGHT HISTORY

Please list your current: Weight _____ Height _____ Age _____

At what age did you begin to have weight problems? _____

What has been your highest weight to date? _____

How much did you weigh when you graduated from high school/turned 18? _____

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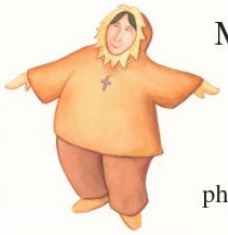

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FAMILY WEIGHT HISTORY

Please tell us about your parents, siblings, children, and spouse; and whether or not they have weight problems.

Ex: Father has had weight issues since the age of 25.

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Does anyone in your family have problems with bleeding, anesthesia, or blood clots in the legs? Ex: Bloods clots on maternal side.

_____

_____

_____

_____

Have you had any recent (circle any that apply)

Cough	Diarrhea	Fever
Sore Throat	Constipation	Chills
Other Chest Pain	Burning urination	Night Sweats

WEIGHT LOSS HISTORY

Please list all of the attempts you have made, including diets, exercise programs, and medications either with organized programs or on your own at home. Please give the approximate date of the attempt, how long you tried it, how much weight you lost, and how much you regained, if any. Please note if a physician or other health care provider supervised the attempt, or if you were part of an organized program at a gym or health club.

Must have a minimum of 3 attempts for insurance purposes documented on the following table.

PROGRAM	WHEN	HOW LONG	WEIGHT LOSS	WT. REGAINED	SUPERVISED
Ex: Atkins	2000	12months	30lbs	40s	Self

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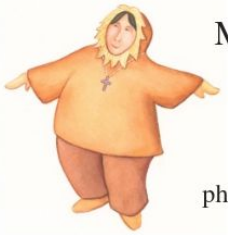

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MEDICAL HISTORY

Please circle here if you have, or have had:

High Blood Pressure/ Hypertension	Asthma	Borderline Diabetes
Heart Attack	Chronic Bronchitis	Diabetes during pregnancy
Heart Failure	Other Lung Disease	Hypothyroidism
Other Heart Disease	Diabetes	Thyroid Problems
Cushing's disease	Hypercholesterolemia	Hypertriglyceridemia
Stomach or Duodenal ulcer	Depression	History of Blood Clots (legs or lungs)
Gout	Gallbladder Disease	Hiatal Hernia

Other Health Issues:

_____

_____

MEDICAITONS

Please list ANY medications or supplements you may take including over-the-counter ones such as aspirin, vitamins, or herbal preparations: (attach list of medications if not enough room)

MEDICATION	REASONS TAKEN	DOSAGE	FREQUENCY
Ex. Metformin	Diabetes	500 mg	Twice Daily

Have you taken any kind of steroids (oral, injections, inhalers) during the past year? **Y** or **N**

If yes, please explain: _____

_____

Medication or food allergies, and the reaction you have to them:

Ex: Penicillin = rash, swelling.

_____

_____

_____

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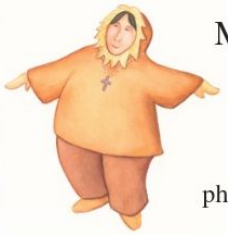

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SURGERIES

Please circle here if you have had prior weight loss/bariatric surgery Y or N

Please list all of the operations you have had, including dates of service.

Surgery	Date, Hospital, Surgeon
Ex: Gallbladder	2003, Alaska Regional Hospital, Dr. No Name

_____
_____
_____
_____

HABITS

Do you use Tobacco Products? Y or N if yes, please explain:

_____

Do you use recreational drugs? Y or N if yes, please explain:

_____

Do you drink alcoholic beverages? Y or N if yes, please explain:

_____

Do you drink caffeinated beverages? Y or N if yes, please explain:

_____

ADDITIONAL MEDICAL INFORMATION YOU FEEL OUR OFFICE MAY NEED:

_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____

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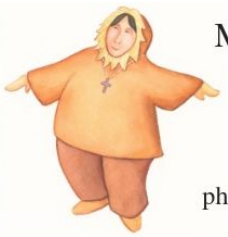

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WEIGHT RELATED PROBLEMS

Please circle all that apply.

- Frequent
  - Indigestion
  - Abdominal gas
  - Belching (burping)
- Burp up sour tasting liquid
- Pain behind breastbone or heartburn
- Swallowed foods sticking in your throat
- Hemorrhoid problems
- Frequent diarrhea
- Frequent constipation
- Abdominal hernia
- Wake with severe headaches
- Become short of breath when
  - Climbing a flight of stairs
  - Climbing half a flight of stairs
  - Crossing a parking lot
- Have occasional severe headaches
- Use a wheelchair
- Are you disabled? ____

- Aches and pains in
  - Back
  - Neck
  - Hips
  - Thighs
  - Knees
  - Legs
  - Ankles
  - Feet
- Difficulty walking
- Swelling of legs, feet, or ankles
- Lose urine with cough or strain
- Racing heart beat
- Frequent numbness of feet or legs
- Abnormal hair growth
- Rashes or infections in skin fold
- Skin aches
- Heavy, frequent, irregular. painful menstruation
- Fertility problems

LIFESTYLE PROBLEMS

Do you have problems with any of the following? If so, please circle them and tell us a little about how much of a problem they are; such as if you can't do something, or if you can only do it with help. These may raise uncomfortable feelings, but they help us document non-medical ways that Morbid Obesity may affect your life.

- Aircraft seating
- Movie seating
- Restaurant booths
- Turn styles
- Dressing
- Putting on socks and shoes
- Looking at yourself in the mirror
- Being seen in public
- Being seen with your family
- Difficulty keeping up on outings
- Playing with your children or pets
- Intimate relations

- Walking on uneven ground
- Walking outside on ice or snow
- Staying inside during the winter for long periods of time because you do not feel safe walking on ice and snow
- Problems reaching (high or low)
- Cleaning after going to the bathroom
- Showering yourself
- Need to take multiple showers every day
- Controlling body odor

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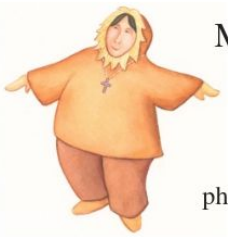

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SLEEP RELATED PROBLEMS

Do you have diagnosed obstructive sleep apnea? Y or N

If NO please fill out the following:

How many pillows do you sleep with? _____

How many times do you wake at night? _____

Read the following situations and use the scale provided to rate your sleepiness.

0= would never dose **1= slight chance of dozing**
2= moderate chance of dozing **3=high chance of dozing**

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting Inactive in a public place	0	1	2	3
Laying down to rest in the afternoon	0	1	2	3
As a passenger in a car for one hour without a break	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3

Check boxes that apply:

- ☐ Someone has observed me stop breathing during my sleep.
- ☐ Have you been told you snore loudly
- ☐ Sleep better on a chair or sofa
- ☐ Awaken with feelings of dread/breathless
- ☐ Wake up as tired as when going to bed
- ☐ Fall asleep while driving, talking, working
- ☐ Wake with severe headaches
- ☐ I snore.
- ☐ I often feel tired, fatigued, or sleepy throughout the day.
- ☐ I have or am being treated for high blood pressure.
- ☐ My BMI is 35 or greater.
- ☐ I am 50 or older.
- ☐ My neck circumference is greater than 40cm (15.75 inches)
- ☐ I am male.

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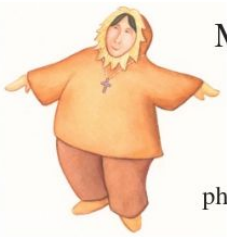

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Notice of Privacy Practice

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. KEEP THIS FOR YOUR FUTURE REFERENCE.

OUR RESPONSIBILITIES UNDER HIPAA

In the course of providing health care we generate, collect and share health-related information pertaining to our patients. Traditionally that information was kept confidential by ethical traditions and a patchwork of regulations that vary by state. Effective April 14, 2003, we have certain responsibilities regarding that information due to congressional enactment of ***HIPAA, the Health Insurance Portability and Accountability Act***. Most state regulations, which afford you greater privileges or additional rights than those prescribed by HIPAA, still remain in effect. (See the last page).

HIPAA regulations set uniform national standards for anyone receiving, handling and safeguarding a person's individually identifiable health information regardless of when it was created or received. Under HIPAA, all information in your physical and psychiatric medical records along with associated billing or payments plus other related demographic data, which can be traced back to you as an individual, is considered **PHI, Protected Health Information**.

Just as we need to inform you of the benefits and risks of a medical procedure and get your written consent for treatment, HIPAA requires us to provide you with a written ***Notice of Privacy Practices***, hereby referred to as **NOTICE** and then ask for your written acknowledgement of your receiving the NOTICE before we can use or disclose your PHI in the course of treating you (except in cases of a medical emergency).

This NOTICE must explain to you, how we use and disclose medical information about you, and inform you of your rights to access and control that information.

On the following pages, this NOTICE explains our current policies effective on the date shown above. We are bound to the provisions of this NOTICE until they are revised and republished. We will always display the most current NOTICE in the patient areas of our office and have available current paper copies. It will also be included on all public web sites that we may maintain. We reserve the right to revise these policies at any time, as the law requires or permits, and the right to apply those changes to any PHI gathered prior to the policy changes.

HIPAA gives you specific rights of control and access to your PHI. Our responsibilities include assigning a *privacy administrator* to assist you with your rights under HIPAA. At any time, you may contact the administrator to request access to your medical records, give written instructions about your PHI, obtain the current version of this NOTICE, file a complaint or ask questions about privacy issues that you may have. Contact information is on the last page.

PROTECTED HEALTH INFORMATION USES AND DISCLOSURES

We routinely use and disclose your PHI for Treatment, Payment, and Health Care Operations

The following are examples of types of uses and disclosures of your PHI that might occur. Some are more likely to happen than others are, some may never happen. These examples are neither exhaustive not an indication of what we intend to do. They are simply examples of the types of uses and disclosures that could be made by our medical practice without your permission as allowed by HIPAA.

Treatment:

We routinely need to disclose your PHI to people inside and outside of our office to provide, coordinate and manage your health care services.

Your physician might require the assistance of another physician or specialist. In such a case, the entire PHI gathered by your personal physician might be of assistance to the specialist enabling them "to put together the pieces of the puzzle" to arrive at your diagnosis.

Service providers such as medical laboratories or x-ray facilities need to be provided your PHI for both diagnostic purposes and billing. Service providers, who perform confirmatory laboratory studies, or specialize in x-ray examinations, need to know the presumptive medical diagnosis of what they are attempting to confirm or eliminate. In such a case we might need to disclose the nature of your problem, how long it existed, what the contributing factors are, etc. to get meaningful results.

We might also need to disclose your PHI to a hospital, or surgical center that provides care to you in their facility. For example, the facility would need to know if you have drug allergies, require a special diet, if you have dentures or wear contact lenses. They will also need your insurance or payment information to obtain authorizations and process your admission.

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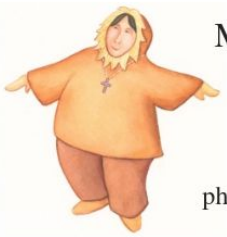

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Prescription medications or other supplies often require us to disclose your PHI. For example, when we telephone a prescription to your pharmacy, we are disclosing some of your PHI. You may need crutches or a wheelchair after surgery for which a durable medical equipment supplier will need PHI information to provide their services.

Payment:

Your PHI is routinely used, only to the extent necessary, to obtain payment for health care services we are providing you. For example, we may contact your insurance company to make a determination of your eligibility for medical services in our office and determine the amount of your co-payment and deductible.

Health plan payers often require supporting PHI be provided to them to determine coverage, medical necessity, and whether they will approve and pay for a service. For example, if you had a fractured leg, we may need to disclose your PHI to your health insurance plan to obtain approvals for a MRI, hospital admission and a surgical procedure. Your PHI may also be disclosed in connection with collecting or reporting a balance due on your account.

Health Care Operations:

We must often use or disclose, as needed, your PHI in order to conduct certain administrative and oversight functions with regard to your health care.

We may need to disclose information to doctors, nurses, technicians, medical students and other staff for purposes of quality improvement activities, employee reviews, training, licensing, or other business activities. For example, we may ask you to sign your name on a sign –in sheet at our registration desk, and then call you by name in the waiting room when your doctor is ready to see you.

We often need to share your PHI with third party "business associates" who perform administrative activities like accountants, lawyers and others who assist with billing and transcription. Efforts are made to ensure that the privacy of your PHI is maintained in such circumstances.

Communication and Education:

We need to use or to disclose some of your PHI in order to contact you by telephone, fax and regular or electronic mail to remind you of your appointments or to respond to your questions. Similarly, to improve the awareness and knowledge of our patient's we sometimes may use your PHI to provide you with educational material or send you newsletters regarding health information, our services, health-related products (for example, vitamins, drugs, diabetic shoes) and new or alternative treatments that may be of interest to you.

Individuals Involved in Your Health Care:

Unless you object, or as stipulated by law, we may release (as it relates to their involvement or responsibility in your care) your PHI to the following: family member relative, close friend, someone else you

Choose, or someone who helps pay for your care. This includes advising them of your location or general condition.

Even if you object, we may still disclose your PHI, if we determine, in our professional judgement that it is in your best interest, especially in cases of emergency. We also may release PHI to an entity (for example, Red Cross) in circumstances of disaster relief so that your family can be notified of your location and condition.

Research; Death; Organ Donation:

We may use or disclose your PHI to limited circumstances for research purposes. When necessary, we must disclose PHI to a coroner, medical examiner, funeral director or to an organ procurement organization for them to carry out their duties.

Workers' Compensation:

Should you become injured at work, we may disclose PHI about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

Oversight of Health and Public Policy:

We disclose PHI to federal, state, and local health and government agencies that oversee activities authorized by law. These include audits, investigations, inspections, licensure and determination of your eligibility for services. These activities may be necessary for the government to monitor the health care system, public programs, its contractors and entities subject to civil rights laws. For example, we must disclose PHI to the U.S. Department of Health and Human Services for purposes of determining whether we are in compliance with federal privacy laws.

Monitoring Public Health Risk and Safety:

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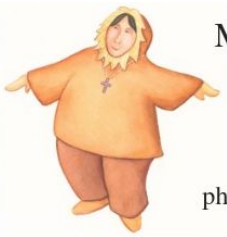

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As required by law, we may disclose your PHI to public health authorities, the Food and Drug Administration, (FDA), or entities that receive information for the purposes of (1) tracking important public health events like births, birth defects, and certain diseases; (2) preventing or controlling disease, injury or disability; (3) notifying people who may be at risk for spreading or contracting a disease or condition; (4) reporting and responding to (an) adverse event (such as medication or dietary supplements reactions), (b) product defects or product recalls to enable repairs or replacements and to; (5) conduct post product release observations.

Military and Veterans:

If you are a member of the Armed Forces, we may release PHI to your military command authorities. Likewise, we would do the same for foreign military authority. For the purposes of determining eligibility, entitlement or benefits as a veteran, we may need to disclose selected PHI to the Department of Veteran Affairs.

Reporting Abuse, Neglect and Domestic Violence:

As health care providers, the law mandates us to report all cases of actual or suspected victimization or violence. Examples include child abuse, domestic violence, elder abuse or neglect, or certain types of wounds or injuries. We may also disclose PHI when it is necessary to prevent a serious threat to the health and safety to you or others. In all cases, these disclosures will be made consistent with requirements of applicable federal, state and local laws.

Legal Process and Proceedings:

If you are involved in a lawsuit or other public civil or criminal proceeding, we may disclose your PHI in response to a court order, summons, warrant, administrative order, grand jury subpoena, discovery request or other lawful process to the extent requested.

Law Enforcement and Criminal Activity:

We may disclose limited PHI to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person, or to protect against fraud and other illegal activities. We may also do so, when necessary, to assist law enforcement officials to capture an individual, who has admitted to participation in crime or who has escaped from lawful custody. We may disclose PHI to law enforcement officials or correctional institutions, which are responsible for their care.

Security Activities:

It may be necessary to release pertinent PHI upon request of federal, state and local officials for purposes of security, clearances, national security intelligence, counter-intelligence, protection services for the President and other public officials, and other activities as authorized by law.

Disclosures and Uses of PHI with Your Written Permission:

We will not use or disclose your PHI for any purpose not previously referenced in this notice without first obtaining your written authorization.

When we need your permission, you may grant it by signing an authorization form. You may later revoke it in writing; except to the extent and action, use of disclosure was already performed as a result of your prior authorization. We have appropriate forms available for these uses.

YOUR RIGHTS AS OUR PATIENT

Access to Your Health Information:

You have the right to inspect and obtain copies of your PHI that may be used to make decisions related to our care of you, generally within 30 days, unless state laws differ. Under Federal laws this does not include psychotherapy notes or information about your PHI compiled for litigation.

As part of your access right, you have the right to authorize and later revoke in writing the use or disclosure of your Phi to anyone for any purpose with limited exceptions. See the above section entitled, *Uses and Disclosures of PHI with Your Permission*.

To gain access to your PHI, which we use to make decisions about your care, you must make a written request, directed to the PHI Privacy Administrator, whose address is provided on the last page. For your convenience we have forms available for these purposes. We will prepare a summarization of your PHI, per request, for a fee. If you request copies, we will charge you duplication costs (see last page) and postage for mailing as allowed under the law.

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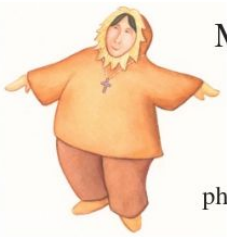

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We may deny your request to access and disclose in certain very limited circumstances: such as, when disclosure would reasonably endanger you or another person or you are in the middle of a medical research study. If you are denied access, you may request that the denial reviewed.

Confidential Communication:

You have the right to request that we communicate with you about your PHI by reasonable alternative means or to reasonable alternative locations (except in emergencies). We will accommodate your request to the PHI Privacy Administrator as long as it provides reasonable alternative means of contact and continues to permit us to bill and collect payment from you. We have forms available for this purpose.

Restriction Request:

You have the right to request a restriction or limitation on your PHI that we use or disclose for your treatment, obtaining payment or conducting health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care of the payment of your care, such as a friend or family member. For example, you could ask that we not disclose information about a surgery that you had. Your request must be made in writing and 1) state what information is to be limited, 2) to whom the restrictions applies and 3) if the restrictions apply to use, disclosure or both.

We are not required to agree to these additional restrictions, but if we do, we will comply with your request except in cases of emergency. Any agreement we may make to your request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Right to Request Amendment to Your PHI:

If you believe that we have incorrect or incomplete PHI about you, you may ask that we amend your PHI. We have special forms available for this purpose. Your request must be submitted in writing to our PHI Privacy Administrator and provide a reason why the information should be amended. Should you fail to do so, your request may be denied. If we believe that the PHI is already accurate and complete, we will deny your request. We will likely deny requests for amendment to any PHI, which was not created by us (unless you provide reasonable evidence that the person or entity that created the information is no longer available to make the amendment). We cannot grant requests to amend PHI, which is not kept by the practice or which is not part of the PHI, that you are permitted to inspect,

If your request for the amendment to PHI is denied, we will provide you our written explanation. If you wish, you have the right to respond with a Statement of Disagreement, on a form that we will provide it will be appended to the PHI, that you wanted amended, along with any rebuttal that we choose to send to you. They will be disclosed together on all future disclosures.

If we accept your request to amend the PHI, we will make reasonable efforts to inform those that you named on your request. At your instruction, we will reasonably send the amendment to others that received the information. The amended PHI will be included on all future disclosures if you instruct us to do so.

Accounting of Disclosures:

You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003, or a date six years before the date of request, whichever is later. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. The first list in a 12-month period is free and for responding to each additional request we may charge you a reasonable, cost-based fee. Contact our PHI Privacy Administrator for a full schedule of charges.

For more information, policy clarification or if you have complaints such as you believe that your privacy rights may have been violated, you should contact the PHI Privacy Administrator indicated below. You also have the right to submit a written complaint to the Secretary of the U.S. Department of Health and Human Services and we will upon request provide you with the appropriate address to file your complaint. <u>We will not retaliate against you if you choose to file any complaint</u>. All communication regarding our privacy practices should be directed to:

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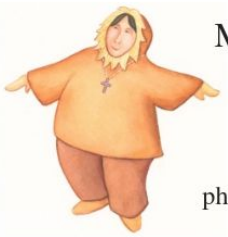

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ADDITIONAL OR SUPERCEDING RIGHTS FOR:

This last page, the *State Preemption Page* of the *Notice of Privacy Practices* is reserved for the inclusion of the **required** disclosure of the State specific rules and regulations that preempt or survive Federal HIPAA regulations for the same or overlapping subjects.

Each State's laws and regulations are unique. Many of the *situations* that need to be addressed in the *Notice* overlap among the states. However, what each state has to say on the same topic can vary widely. To get a flavor of these subjects, the following are samples of topics covered on various *State Preemption Pages* of this *Notice*.

- *Access & Denial of Access to Your Medical Records*
- *Amendments to Your Medical Records*
- *Authorization to Release Your Medical Records*
- *Charges for Copies of Your Medical Records*
- *Communicable Diseases, HIV/AIDS Status, Test Results or Diagnosis*
- *Doctor-Patient Privilege*
- *Disclosure Pursuant to Legal Process and Proceedings*
- *Informed Consent for Release of PHI*
- *Medical Records That Are Illegible or Not In English*
- *Parent's Rights of Access to a Child's Medical Record*
- *Re-Disclosure of Your Medical Records*
- *Rights to Enter a Statement into Your Medical Record*
- *Subpoenas for Medical Records*
- *Termination or Temporary Cessation of Practice*
- *Use and Disclosure of Your PHI Information*