Welcome To Breast Care Specialists!

Please read and complete this packet PRIOR to your visit to avoid delays at the time of your appointment. If your insurance policy requires a referral to see our doctors, please ensure that your PCP office has completed the referral and sent a copy to our office prior to your visit. Failure to have the referral may result in a delay of your appointment.

Please arrive at our office 30 minutes prior to your scheduled appointment time.

We are pleased to welcome you to our practice. Our practice is very unique in that we can diagnose and treat most breast problems in one or two visits. However, in order to accomplish your diagnosis and treatment properly, we must have certain information at the time you check in.

1. **PLEASE COMPLETE ALL PATIENT INFORMATION AND HEATLH SURVEY FORMS ENCLOSED.**
    - Please fill them out and bring them with you to your first visit.
    - If you experience difficulty understanding or answering any of the questions on the Health Survey form, please leave the answer section to the question blank. We will be please to assist you with anything you did not understand when you come in.
2. **PLEASE BRING TO YOUR APPOINTMENT ANY MAMMOGRAM, ULTRASOUND FILMS AND REPORTS TAKEN AT ANTOHER IMAGING FACILITY.**
    - You probably cannot be seen if you arrive without these films and reports since they are necessary for the doctor to use in making her diagnosis.
    - Films mailed to ultrasound may take three weeks to arrive. If films were taken at a facility in town, please pick them up and bring them with you. Films coming from out of town may be sent via an express carrier mail if your appointment is less than 3-4 weeks away. To check whether films have arrived with ultrasound, please call and speak with our film librarian, 404-255-8086, ext. 266.
3. **IF YOU HAVE AN HMO OR POS TYPE OF INSURANCE PLAN YOU MAY BE REQUIRED BY YOUR INSURANCE COMPANY TO OBTAIN A REFERRAL AUTHORIZATION TO BE SEEN AT OUR OFFICE.**
    - Some plans allow the referring physician to issue the referral. Other plans require the referral to come from the patient's primary care physician. You should contact your insurance carrier if you are uncertain which kind of plan you have.
    - Please note, WE DO NOT PERFORM "ROUTINE" OR "SCREENING" MAMMOGRAMS. "Preventive care" mammogram benefits, usually, do NOT apply to services received in our office. If you call to speak with a representative at your insurance company, be sure the person you speak with understands this is a DIAGNOSTIC facility and that we perform only diagnostic mammograms and sonograms (ultrasound).
    - If you do need a referral authorization, please ask your physician's staff to fax a copy to our office AND send a copy to you to BRING WITH YOU. (We have experienced delays with faxed referrals). Our contracts with managed-care insurers do not allow ultrasound to see you without an appropriate referral authorization. If you arrive for your appointment without a referral, your insurer may not cover the cost of treatment for a diagnosis, including cancer, made during a non-referred visit. Should you have questions about what should be included in your referral, our referral coordinator will be glad to help you. You can reach her at telephone extension 208.

Please allow plenty of time for your appointment, usually 3 hours. We are a diagnostic center and serve only high-risk patients. Often, imaging and examination reveal problems requiring immediate, unscheduled procedures. Please be assured that you will receive the same time and attention as the patient before you.

Written directions and a map to our office are enclosed. Please call us at 404-255-8086 if you have questions or need further information.

PATIENT AUTHORIZATION FOR USE BY BREAST CARE SPECIALISTS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing, I authorize BREAST CARE SPECIALISTS, LLC to use and/or disclose certain protected health information (PHI) about me to the physicians listed below or any other physician that you would like to receive a copy of your medical record (PHI) generated as part of your establishment as a patient of BREAST CARE SPECIALISTS, LLC. *Failure to authorize release of PHI may prevent the exchange of vital Information associated with caredelivery.*

Name Address Phone Fax

Referring Physician: _____

_____

Primary Care (Internist, Family Doctor): _____

_____

OB/GYN: _____

_____

Other: _____

_____

This authorization permits **BREAST CARE SPECIALISTS, LLC** to use and/or disclose the following individually identifiable health information about me (please check all that apply - if unsure, please check all boxes)

_____ Office Notes (office visist MD notations)
_____ Ultrasound Reports
_____ Other: _____
_____ Mammogram Reports
_____ Pathology Reports

The information will be used or disclosed for the following purpose: (please check)

_____ **At the request of the patient**
_____ Other

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will automatically renew. The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, only in some cases a fee for the copying of the information.

☑ I hereby give my consent for BREAST CARE SPECIALISTS, LLC *to* use *and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations* (TPO}. (The Notice of Privacy Practices provided by BREAST CARE SPECIALISTS, LLC describes such uses and disclosures more completely.) Without consent, PHI will not be disclosed and may delay patient-requested activity.

☑ I have the right to review the Notice of Privacy Practices prior to signing this consent. BREAST CARE SPECIALISTS, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, 975 Johnson Ferry Rd, Suite 500, Atlanta, GA 30342.

☑ With this consent, BREAST CARE SPECIALISTS, LLC *may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.*

☑ With this consent, BREAST CARE SPECIALISTS, LLC *may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."*

By signing this form, I am consenting to allow BREAST CARE SPECIALISTS, LLC to use and disclose my PHI to carry out TPO. I do not have to sign this authorization in order to receive treatment from BREAST CARE SPECIALISTS, LLC. In fact, I have the right to refuse to sign this authorization. When my Information isused or disclosed pursuant to this authorization, It may be subject to redlsclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Breast Cara Specialists, LLC

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, If applicable

BREAST CARE SPECIALISTS, L.L.C.

A multidisciplinary approach to Breast Health

Jennifer Amerson, M.D., FACS
Diplomate American Board of Surgery

Brenda Simpson, M.D., FACS
Diplomate American Board of Surgery

Meredith Redden, M.D., FACS
Diplomate American Board of Surgery

Carrie Stallings, M.D., FACS
Diplomate American Board of Surgery

Deborah Cunningham, M.D.
Diplomate American Board of Radiology

Esther Udoji, M.D.
Diplomate American Board of Radiology

Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice revision date September 23, 2013.

_____ _____ _____

Patient or Personal Representative's Signature | Patient or Personal Representative's Name Printed | Patient's Date of Birth

_____ _____

Personal Representative's Relation to Patient | Date

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Summary Privacy notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of Summary Privacy Notice, However, acknowledgement has not been obtained because

_____Patient refused to sign the Summary Privacy notice Acknowledgement

_____Patient was unable to sign because_____

_____There was a Medical Emergency. Provider will attempt to obtain acknowledgement as soon as is practical.

_____Other reason: _____

_____

_____ _____ _____

Employee's Name | Employee's Signature | Date

Authorization of Discuss Medical Care

I hereby authorize Breast Care Specialists, LLC to discuss any of my medical care needs (including appointments, results, continuing care, treatments, etc.) with the following people:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship: _____ Phone: _____

_____ _____

Patient or Personal Representative's Signature | Date

Our Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our financial policy at any time. Please ask us if you have any questions about our financial policy or your financial responsibility.

All new patients are asked to complete a Patient Information Form prior to being seen by the provider. We ask that you complete all of the information including your insurance information. We will also ask to make a copy of a picture i.d. and your insurance card to remain a permanent part of your chart.

INSURANCE COVERAGE & PATIENT RESPONSIBILITY

You are responsible for co-payments, co-insurance, non-covered services, or any patient responsible balance at the time of service. If you are covered by a plan in which we participate as a provider, we will file your insurance claim. In the event your insurance company does not pay the full balance, we will notify you so that you may contact your insurance carrier to resolve your account. Be advised that some insurance companies treat coverage for diagnostic imaging differently than screening imaging and it may be subject to your plan deductible. Please refer to your specific plan document and coverages for your benefits. Please remember payment responsibility rests with the patient, if no coverage exists for services performed.

- **All non-covered patients are expected to pay for services in full at the time services are rendered.**
- **Please advise the office personnel of any changes in your insurance or mailing address.**
- **Payment arrangements can be negotiated prior to services being rendered. Please ask for assistance, if required.**

Should it ever become necessary to use the services of an outside collection agency to collect your account, you could be responsible for any costs incurred for that purpose.

REFERRALS

If your visit requires a referral from a primary care provider, we will alert you via phone prior to your visit and offer our assistance. ***IF YOU DO NOT HAVE A REFERRAL FOR TODAY'S VISIT...*** you should reschedule immediately. Should you choose to be seen without a referral, you understand that the charges incurred may be uncovered and that any diagnosis resulting from the encounter may also be uncovered and may prevent future services from coverage (i.e. surgery).

ASSIGNMENT OF BENEFITS

I hereby authorize Breast Care Specialists, LLC to bill my insurance company directly for the services rendered. I understand that I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration, intermediaries, other providers of treatment or procedures, or intermediaries needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request for payment of medical benefits either to myself or to the party who accepts assignment of benefits.

WORKERS COMPENSATION

Worker's compensation patient will be seen only after the proper authorization and documentation has been received.

UNACCOMPANIED MINORS

The parents or guardians will be responsible for the full payment unless covered by a participating managed care plan. Authorization to treat an unaccompanied minor must be on file.

We thank you for carefully reading this financial policy. We trust that you understand its contents. If you have any questions, please feel free to ask. Please sign below to indicate your understanding and acknowledgment of this policy.

Responsible Party Signature	Patient Name (Please Print)	Date

BCS

METHODS OF PAYMENT

CASH, CHECKS, VISA, MASTERCARD, AMEX AND DISCOVER are all accepted. We also offer automatic debit for patient responsible balances.

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Diplomate American Board of Radiology

SCREENING MAMMOGRAM VS DIAGNOSTIC MAMMOGRAM

While the technology is basically the same there are a few key differences between screeninq.and diagnostic mammograms that you should know:

- Screening mammograms are allowed and for by insurance once a year.
- A radiologist (physician) does not need to be present for a screening mammogram: whereas the interpreting radiologist is present to review the diagnostic mammogram.
- Diagnostic mammograms take longer than screening mammograms since the radiologist reviews the images while you are in the office. The radiologist may ask the technologist to take more images of the breasts to evaluate areas of concern.
- In addition to the regular 20 mammogram, the 2D/3D combination tomosynthesis mammogram takes multiple images of breast tissue to recreate a picture of the breast (please see the attached information from the American College of Radiology)

******PLEASE INITIAL******

_____ I understand that may be receiving a diagnostic 2D or a diagnostic 2D/3D combination tomosynthesis mammogram today based on what was ordered by my physician. <u>It is not a screening mammogram.</u>

_____ I understand that my service may be applied to my deductible and/or co-pay with my insurance plan.

_____ I understand that I should consult with my insurance regarding coverage of this service should any questions arise.

Patient Name_____

Patient Signature_____

Date _____

Breast Care Specialists

PLEASE BE ADVISED: We are a diagnostic facility that specializes in breast care. Your Insurance plan may not cover a diagnostic mammogram at 100% as it does for a screening mammogram. Please check with your insurance company if you have questions about your coverage for diagnostic services.
_____(Please Initial)

PATIENT INFORMATION

Name:	Email Address:
c/o (if a minor):	Cell Phone#:
Address 1:	Home Phone#:
Address 2:	Work Phone#:
City:	Employer:
State: Zip:	Emergency Contact:
Date of Birth:	Emergency Phone#:
Sex (circle one): M F Marital Status (circle one): M S D W	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID Number:	ID Number:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:

REFERRAL INFORMATION

Referred by Doctor (First and last name):	Referred by Other (family,friend,etc):
Phone Number:	
Does your insurance require an authorization # from your primary care physician? Yes or No	
Primary Care Physician:	
Phone Number:	

I acknowledge that the physicians of BCS may not be a part of the provider network for my insurance plan. I understand it is my responsibility to verify this information with my insurance company. I also acknowledge it is my responsibility to obtain an authorization number from my primary care physician if required by my insurance plan.

Unless prior arrangements have been made with our business office, payment for services rendered are due at the time of service.

I hereby authorize the physicians of BCS to furnish the necessary information concerning my illness to my insurance company and I hereby assign to the physicians, all payments for medical services rendered to myself or my dependents. I understand I am responsible for obtaining my coverage information from my insurance plan and I also understand I am responsible for any amount not covered by my insurance.

Your signature serves as notice to treat a child if the patient is a minor.

Date:_____Signature:_____Relationship:_____

Breast Care Specialists **Health Survery From** **SP NRR REF OV MG US BX**

Dear Patient,
Thank you for choosing Breast Care Specialists, LLC for your care. Please note that we are a **diagnostic facility. We do not offer screening or preventative services.**

Please check with your insurance provider as you may incur a cost.

Name: _____ Height: _____

DOB: _____ Weight: _____

Today's Date: _____

Section 1:
Reason for visit: Please check *all* that apply

___ Routine visit. I have no changes on my self-breast exam
___ Risk Assessment.
___ Second opinion.
___ New Problem. *Please detail in section B.*
___ Abnormal imaging. Please check all that apply.
___ Abnormal mammogram ___ Abnormal CT or MRI ___ Other (please detail): _____
___ Abnormal ultrasound ___ Abnormal PET scan _____
___ Other. Please explain:
_____

Referring Physician(s):
Please indicate all physicians whom you would like to receive a report of today's visit.

Primary Care: _____
OB\GYN: _____
Other: _____

Preferred Pharmacy:
What is your preferred pharmacy?

Name: _____
Location: _____
Phone: _____

Allergies:
Please list any allergies to medications

_____

Please list current medications. _____
_____

___ YES ___ NO Have you had a recent vaccine (last 3 months?)
___ YES ___ NO Have you been tested for the Coronavirus (Covid 19) in the past two weeks?
- If so what was the result? _____
___ YES ___ NO Masks are no longer required. Would you prefer your providers to wear a mask?

Section B: Patient Name: _____

For each selection, please indicate area of concern on the diagram.

Please check the appropriate anwsers.

___ New palpable/thickening area(s) of concern.

____ Right____ Left ____ Both

- Aprox size: ____ BB ____ Pea ____ Grape ____ Lemon
- When was it first noticed? _____

___ YES ____ NO Has it changed since onset? _____

___ New nipple discharge.

____ Right____ Left ____ Both

- Color: ____ Bloody ____ Milky ____ Clear____ Urine colored
  ____ Other (describe): _____

____ Single hole ____ Multiple holes

____ Does it come out by itself ____ Only comes out with squeezing

____ Comes out by itself

___ New nipple retraction.

____ Right____ Left ____ Both

___ New skin change. Please detail:

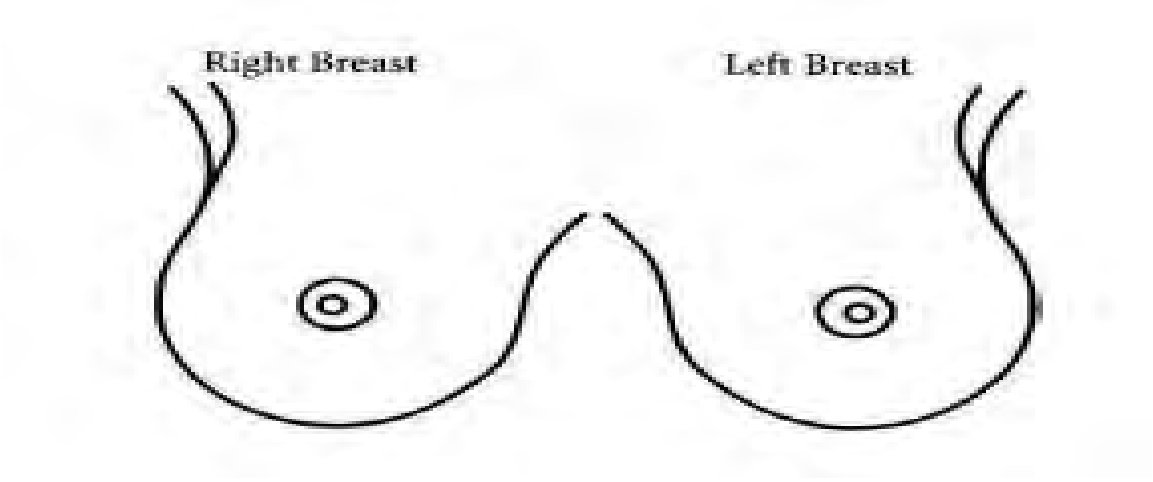
_____

___ New pain/tenderness.

____ Right____ Left ____ Both

____ Focal Area ____ Entire Breast(s)

___ Other. Please detail: _____



FOR OFFICE USE ONLY:

MG TECH INITIALS: _____

US TECH INITIALS: _____

Section C:

Patient Name: _____

Personal Breast History:

___ YES ___ NO Have you ever been diagnosed with breast cancer?

Which breast? ____ Right ____ Left Date: _____

Type of cancer: _____

Type of surgery:

____ Lumpectomy ____ Mastectomy ____ Sentinel node ____ Axillary dissection

Please list any prior breast biopsy or surgery:

Date	Type of biopsy/surgery	Side (R/L)	Physician	Diagnosis (if applicable)

___ YES ___ NO Do you have implants? If so, silicone or saline: _____

Date placed: _____ Replaced: _____

___ YES ___ NO Have you ever had radiation treatment to the breast/chest or neck? Please detail

_____

Personal imaging history:

___ YES ___ NO Have you ever had a mammogram, ultrasound or breast MRI?

Please list locations and dates.

Location	Date:	Type of exam:

Past medical history: Please detail if able.

___ YES ___ NO Do you have asthma, emphysema, chronic bronchitis, COPD or other chronic lung disease?

___ YES ___ NO Clotting disorder

___ YES ___ NO Heart disease/heart attack

___ YES ___ NO High blood pressure

___ YES ___ NO High cholesterol

___ YES ___ NO Do you have stomach ulcers or peptic ulcer disease?

Past medical history: (continued) Patient Name: _____

___ YES ___ NO Liver disease
___ YES ___ NO Thyroid Disorder
___ YES ___ NO Stroke or Neurologic disorder
___ YES ___ NO Autoimmune disease (Lupus, Scleroderma, etc.)

Please list any surgeries and when you had them.

Date:	**Type of Surgery:**

Other medical problems (please detail).

_____

Review of Systems: Please check all that apply.

Constitution *:*
___ Fever or chills ___ Weight loss/gain
___ Appetite Loss ___ Fatigue

Cardiovascular :
___ Chest pain ___ Swelling
___ Abnormal heart rhythm

Gastrointestinal :
___ Abdominal pain ___ Heartburn
___ Nausea/vomiting ___ Diarrhea/Constipation

Endocrine :
___ High blood sugar ___ Thyroid problems
___ Steroid usage

Pulmonary:
___ Wheezing ___ Cough
___ Shortness of breath

Neurologic :
___ Seizures ___ Speech problems
___ Tingling extremities

Genitourinary :
___ Difficulty/frequent urination
___ Ovarian cysts ___ Endometriosis

Psychiatric :
___ Depression ___ Anxiety
___ High stress

Risk assessment:

___ YES ___ NO Have YOU or any of your family members been diagnosed with breast cancer?
- Please list: relationship and age:

_____

_____

___ YES ___ NO Have YOU or any of your family members been diagnosed with ovarian cancer?
- Please list: relationship and age:

_____

_____

___ YES ___ NO Have YOU or any of your family members been diagnosed with other cancers?

_____

___ YES ___ NO Have you or your family members had genetic testing?
- If so When? Where? Results?

_____ _____ _____

Risk assessment: (continued) Patient Name: _____

___ YES ___ NO Are you pregnant?

___ YES ___ NO Are you breastfeeding?

What is your menopausal status: ____ Pre ____ Peri ____ Post

- Age of onset of menopause if applicable: _____

___ YES ___ NO Were you age 12 or younger when you started menstruating?

- What age did you start? _____

___ YES ___ NO Are you of Ashekenazi descent?

___ YES ___ NO Have you had a hysterectomy?

___ YES ___ NO Have you had your ovaries removed?

___ YES ___ NO Have you had your fallopian tubes removed?

___ YES ___ NO Are you currently taking or have you in the past taken:

____ Hormone replacement therapy?

Name:	Dosage	Dates

____ Oral contraceptives: name/dose/date

Name:	Dosage	Dates

____ Infertility drugs? Name/dose/date

Name:	Dosage	Dates

____ Risk reduction treatments?

____ Tamoxifen ____ Arimidex ____ Fareston ____ Other: _____

___ YES ___ NO Were you 30 years of age or older when you gave birth to your first child?

_____ N/A

- How old were you with your first live birth? _____

Please list ages and sex of your children: _____

___ YES ___ NO Have you breast fed any child for greater than six weeks?

_____ N/A

___ YES ___ NO Do you have personal history of osteoporosis?

___ YES ___ NO Do you currently smoke?

- If so how long, _____ and amount? _____

___ YES ___ NO Did you previously smoke?

- If so how long, _____ and amount? _____

___ YES ___ NO Do you drink alcohol?

- If yes please list number of drinks per week. _____

___ YES ___ NO Do you have a personal history of recreational drug use?

How many times per week do you exercise? _____

Procedure Risks: Patient Name: _____

___ YES ___ NO Do you have any chronic medical illness?
- Please list: _____

___ YES ___ NO Have you tested positive for hepatitis or HIV?

___ YES ___ NO Do you take aspirin, Motrin or other pain relievers on a regular basis?
- If so please list and amount. _____

___ YES ___ NO Do you take Warfarin, Xarelto Coumadin, or other blood thinners?
- If yes please list. _____

___ YES ___ NO Do you have a clotting disorder?

___ YES ___ NO Do you take antibiotics before dental procedures?

___ YES ___ NO Do you have serious health problems with your liver, lungs, kidneys or heart?
- Please list. _____

___ YES ___ NO Have you ever had problems with anesthesia?
- Please detail. _____

___ YES ___ NO Do you have a pacemaker? **Most pacemakers are not compatible with MRI.**

Signature: _____

Date: _____

Summary of Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health Information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable Inferences of your best interest In allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not share your health Information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstance. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health Information to provide you with appointment reminders (such as voicemail messages, postcards or letters.)

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

You have the right to Obtain a Paper Copy of this Privacy Summary Notice as well as the full Privacy Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns. please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact Information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and/or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager/Privacy Leader