Colorado Gastroenterology
Trusted Consultation, Compassionate Care

Thomas E. Trouillot, M.D.
Jennifer W. Brenner, M.D.
Kevin S. Sieja, M.D.
Kevin M. Rufner, M.D.

# Patient Demographic Information

Full Legal Name _____

Date of Birth _____ Sex **M** **F** **T** _____
Pronouns

Physical Address _____

City, State, Zip _____

Emergency Contact Name _____

Relationship _____ Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Pharmacy name _____ Phone _____

Address _____

☐ I am the patient. I am the financially responsible party and/or the insurance policyholder.

☐ I am the patient, but someone else is the policyholder for my insurance.

☐ I am the patient, but a Power of Attorney relationship is in place.

Responsible Party Name _____

Relationship _____

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# Health History

Full Legal Name_____

Past Medical Conditions: _____

_____

_____

Past Surgical History: _____

_____

_____

## Family History

| | Father | Mother | Siblings | Children |
|---|---|---|---|---|
| Gallstones | | | | |
| Colon Polyps | | | | |
| Colon Cancer | | | | |
| Pancreatitis | | | | |
| Liver Disease | | | | |
| Crohn's Disease | | | | |
| Ulcerative Colitis | | | | |
| Other Cancer | | | | |
| Other Illness | | | | |

If no longer living, please note age and cause of death:

_____

_____

_____

_____

_____

## Social History

Marital Status:

- ☐ Single
- ☐ Partnered
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow(er)

Significant others name

_____

Tobacco Use:

- ☐ Non-smoker
- ☐ Smoker packs/day_____ years_____
- ☐ I quit smoking year:_____

Alcohol Use:

- ☐ None
- ☐ _____drinks/day _____drinks/week
- ☐ I quit drinking year:_____

Drug Use:

- ☐ Marijuana
- ☐ Cocaine
- ☐ Other:_____

_____

_____

Occupation:_____ Retired? Y N

Recent Travel: _____

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# Health History

Full Legal Name _____

## Allergies - Please list ALL allergies to medication, environment food etc.

| Name of allergen | Describe reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Name of allergen | Describe reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Medications - Please list ALL prescription medication(s), herbal medication(s), and vitamins/minerals.

| Name of med/supplement | Dosage | Frequency | Route | Reason for med |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If you are given prescriptions for a controlled drug (schedule II-V). your identifying information will be entered into Colorado Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you. Your prescription information in the database is protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have the right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

_____ Initial/Date

## Colorectal Cancer Screening

Y N I had a Fecal Occult Blood Test (FOBT)

Y N I had a flexible sigmoidoscopy in the past 4 yrs

Y N I had a colonoscopy in the past 9 yrs

Y N I had a CT colonography in the past 4 yrs

Y N I had a Fecal DNA test in the past 2 yrs

Date of last flu shot:
_____

Date of pneumonia vaccine:
_____

Date of COVID-19 vaccine:
_____

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# Health History

Full Legal Name_____

## General
Y N Chronic fatigue
Y N Thyroid disease
Y N Weight change
Loss_____lbs_____time
Gain_____lbs_____time
Y N Bruise easily
Y N Bleed too long
Y N Anemia
Y N Chills
Y N Fever

## Skin
Y N Rashes
Y N Allergic reactions
Y N Hives
Y N Growths

## Neurological/ Psychiatric
Y N Stroke
Y N Tremor/ hands shaking
Y N Numbness/tingling
Y N Depression
Y N Nervousness
Y N Problems sleeping
Y N Memory loss
Y N Seizures
Y N Panic attacks
Y N Migraines
Y N Anxiety

## Eyes, Ears, Nose, & Throat
Y N Ringing in ears
Y N Ear infections
Y N Dizzy spells
Y N Sinus trouble
Y N Nosebleeds
Y N Hoarseness
Y N Eye infections
Y N Poor Vision
Y N Glaucoma
Y N Cataracts

## Bones and Joints
Y N Arthritis/ Rheumatism
Y N Back Pain
Y N Weak bones
Y N Swollen Joints

## Urinary
Y N Urinary infections
Y N Kidney stones
Y N Painful urination
Y N Urination at night
Y N Blood in urine
Y N Decreased urine flow/force

## Heart
Y N Chest Pain
Y N High blood pressure
Y N Palpitations
Y N Ankle swelling
Y N Irregular heart beat
Y N Blood clots

## Gastrointestinal
Y N Diarrhea
Y N Heartburn
Y N Black stools
Y N Constipation
Y N Stomach Pain
Y N Poor appetite
Y N Nausea
Y N Vomiting
Y N Bloating
Y N Liver disease
Y N Gas
Y N Trouble swallowing
Y N Blood in stool

## Lungs
Y N Pneumonia
Y N Asthma
Y N Bronchitis
Y N Cough
Y N Shortness of breath

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# Treatment Plan

Full Legal Name_____

Primary Care Physician_____ Phone _____

What is the reason for your visit today?_____

_____

_____

How long have you been experiencing the problem(s)?_____

New tests or labs done since last visit?_____

_____

_____

The remainder of this page is for physician use only.

## Physician notes and treatment plan

### Labs

- ☐ CBC
- ☐ CMP
- ☐ LFT
- ☐ ITG
- ☐ IgA
- ☐ IgG
- ☐ CRP
- ☐ ESR
- ☐ Vit B
- ☐ Vit D
- ☐ AFP
- ☐ Hep Panel
- ☐ Hep B Ab
- ☐ Hep C Vital Load
- ☐ Hep C Genotype
- ☐ TB
- ☐ 6-MP
- ☐ Remicade levels
- ☐ Humira levels
- ☐ Stool Culture
- ☐ Calprotectin
- ☐ Ova & Parasite
- ☐ C-diff
- ☐ Fecal fat
- ☐ Fecal elastece
- ☐ Other:_____
  _____
  _____
  _____

### Imaging

- ☐ CT w/o
- ☐ CT w/contrast
- ☐ CT Enterography
- ☐ CT Colonoscopy
- ☐ CT anglography
- ☐ MRI w/o
- ☐ MRI w/contrast
- ☐ MRI Enterography
- ☐ MRI w/o MRCP
- ☐ Sitzmark study
- ☐ Gastric emptying
- ☐ Esophagram
- ☐ Liver bx
- ☐ UGI/SBFT
- ☐ Fibroscan
- ☐ Hida scan w CCK
- ☐ Ultrasound_____
  _____
- ☐ X-ray_____
  _____

### Procedure

- ☐ Colonoscopy
- ☐ EGD
- ☐ ERCP
- ☐ FLIP
- ☐ Flex Sig w/ BX

Notes:

### Other tests

| | |
|---|---|
| Esophageal Test | ☐ Manometry-no impedance ☐ on meds ☐ off meds<br>☐ EFT/includes manometry & impedance ☐ on meds ☐ off meds<br>☐ 24 pH (acid only) ☐ 24 pH + impedance - non acid reflux ☐ 24 pH + impedance - acid reflux |
| Breath Test | ☐ Bacterial ☐ Lactose ☐ Fructose ☐ Capsule ☐ Aglle Capsule |
| Anorectal | ☐ Manometry ☐ Pudenal Nerve ☐ Sponge ☐ Rectal US ☐ PIE |
| Biofeedback | ☐ Biofeedback ☐ Electrical Stim |

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# Colorado Gastroenterology Financial Policy

Full Legal Name _____

| | |
|---|---|
| Cancellation Policy | **Procedures** – We require you provide our office three (3) full business days' notice in the event I need to reschedule or cancel a procedure with the physician. This includes appointments for colonoscopy, upper endoscopy (EGD), flexible sigmoidoscopy and ERCP. If I miss an appointment for a procedure without providing three (3) full business days' notice, we consider this a missed appointment and a $100 fee may be assessed.<br>**Office Visits** – We request you give our office at least one (1) full business days' notice in the event I need to reschedule or cancel an office appointment with the physician. If I miss an appointment for an office visit without providing at least one (1) full business days' notice, we consider this a missed appointment and a $50 fee may be assessed. |
| Medical Records | **Medical Records Requests** – Requests for medical records must be received in writing. A fully executed "Authorization to Release Medical Records" form must be used and are available upon request. If Colorado Gastroenterology is releasing records to an entity not covered under HIPAA, a fee will be charged based on the number of pages in the record. I will be informed of the total charges. The fee must be paid before any and all records are released. |
| Claim Processing and Patient Responsibility | Your insurance coverage is a contract between you and your carrier. It is my responsibility to know and understand the requirements of my Health Insurance Plan. If a referral and/or pre-authorization for an initial consultation or follow up visit(s) is required, I will be responsible for obtaining and submitting the required documentation to Colorado Gastroenterology prior to my visit. It is my responsibility to verify with my insurance company that Colorado Gastroenterology is a participating provider with my plan. If I change insurance companies, I will be responsible for informing Colorado Gastroenterology of the change and present new insurance card(s). If updated information is not provided, and claims are denied for any reason, I will be responsible for payment for all services provided.<br>We will bill your primary and/or secondary insurance carrier(s). If we have an established contract with your insurance company, we will follow the terms, conditions and requirements of our contract. It is your insurance company's responsibility upon timely receipt of your claim, to process the claim, make the final determination regarding eligibility and finalized payment of benefits. We will process your carrier's payments and adjustments according to our contract and as the Explanation of Benefits documentation requires. In the case of a patient balance that is not satisfied by your insurer OR a charge to credit card payment method OR a payment plan, I may receive a monthly statement for the outstanding balance(s). I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance. Patient responsibility balances are due upon receipt.<br>**Non-Contracted Insurance** - If Colorado Gastroenterology does not have a contract with my health insurance carrier, I will be responsible for all charges not covered under my health insurance plan. **Self-Pay patients** will be required to pay 100% of all charges at the time of service. **Worker's Compensation** requires written approval/ authorization by my employer and/or my worker's compensation carrier prior to my initial visit. If my claim is denied, I will be responsible for payment in full. We will also verify my employer or my employer's carrier assumes responsibility for all charges incurred. If we cannot verify responsibility or are unable to obtain information for my employer's worker's compensation insurance, I will be financially responsible for all charges. **Personal Injury/Third Party Liability** - We will not bill third party liability coverage. |
| Payment Plans | If terms and timelines are mutually discussed and agreed upon, Colorado Gastroenterology may opt to offer the option of an automated payment plan. Colorado Gastroenterology's standard payment plan will apportion the outstanding balance, divided into no more than three (3) equal, monthly payments, payable via a valid credit card. The first payment is due at the time the payment plan is established, second payment is due in thirty days and the third/final payment is due in 60 days. Your agreement to this payment plan will be recorded in Colorado Gastroenterology's financial system and will act as my authorization to charge my credit card on a monthly basis. This authorization remains in effect until the outstanding balance has been satisfied. My credit card statement will show the monthly payment and will serve as my receipt. I have read and understand the policies associated with establishing a payment plan. By signing this document, I am NOT setting up a payment plan. I acknowledge it is my responsibility to initiate contact with the Colorado Gastroenterology administration team to discuss my payment plan. |
| Payment Processing | I agree to provide Colorado Gastroenterology and/or its designated payment agent with my debit/credit card information. I understand my signature and payment information is maintained on file for future use by Colorado Gastroenterology. My information will be requested as a new patient and updated annually. In compliance with the Payment Card Industry Data Security Standard (PCI DSS) requirements, Colorado Gastroenterology participates in a mandatory quarterly ControlScan (ASV) and maintains an Attestation of Security Scan Compliance. My credit card information will be securely stored in our PCI compliant merchant processing system and not accessible through our electronic health record. My debit/credit card information will be submitted on a separate page which will be destroyed upon entry into the PCI compliant merchant processing system. |
| Patient Signature | **I acknowledge I have read, understand and agree to comply with the Colorado Gastroenterology Financial Policy**<br>Sign here<br>Patient or responsible party Signature _____ Relationship _____ Date _____ |

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# Colorado Gastroenterology Financial Policy

Full Legal Name _____

## Permission to communicate protected health information

We take our responsibility to protect your health information very seriously. Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? ____ No ____Yes. If yes, please complete the following section: **I grant permission for my Protected Heath Information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the individuals others listed below:**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

**The type of information to be disclosed is as follows: ( please check the appropriate options)**

☐ Laboratory results ☐ Biopsy results ☐ Medical instructions or advice ☐ Prescription drug information

Other, please specify:_____

**I understand that this may include detailed personal medical information including medical services to be provided, notification that items such as refills are ready for pick-up as well as any information listed above.**

This permission is valid until _____ (date). I understand I may revoke or modify this specific authorization and that revocation or modification must be in writing.

Sign here

_____

Patient or responsible party Signature Relationship Date

## Notice of Privacy Policy

I acknowledge I have received Colorado Gastroenterology's Notice of Privacy Practices, which described the ways in which the practice may use and disclose my healthcare information for my treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand I may contact the Privacy Office designated on the notice if I have a question or complaint. I understand this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices. This authorization may be revoked at any time in writing, except to the extent that Colorado Gastroenterology has taken action in reliance on the use or disclosure indicated in the authorization.

Sign here

_____

Patient or responsible party Signature Relationship Date

Office Use Only: Complete this section if you are unable to obtain a signature. If the patient or personal representative is unable or unwilling to sign acknowledgement, or the acknowledgement is not signed for any other reason, state the reason: _____ Describe the steps taken to obtain the patient's/personal representative's signature: _____ Signature and printed name of practice representative: _____

## CORHIO

Colorado Gastroenterology endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

## Consent and Assignment of Benefits Release Authorization

General Consent to Treatment - By signing below, I (or my authorized representative on my behalf) authorize Colorado Gastroenterology to conduct any diagnostic examinations, tests and procedures, and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Assignment of Benefits/Signature on File - I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment directly to Colorado Gastroenterology for medical services rendered to me and/or my dependents. My signature below constitutes my consent. Authorization to Release Information - I hereby authorize Colorado Gastroenterology to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; to process insurance claims generated in the course of examination or treatment; and to allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I have read, understand and agree to Colorado Gastroenterology Financial Policy. BY MY SIGNATURE BELOW, I certify the information provided on and in connection with these series of documents is true, accurate and complete. I also certify that I have read, understand and agree to all provisions.

Sign here

_____

Patient or responsible party Signature Relationship Date

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1960 Ogden Street, Suite 220, Denver, CO 80218
13701 E Mississippi Ave, Suite 380, Aurora, CO 80012
Phone: 303-861-0808 Fax: 303-861-2193

Kevin Sieja, MD
Jennifer Brenner, MD
Kevin Rufner, MD
Thomas Trouillot, MD

# NOTICE OF PRIVACY PRACTICES

**Effective Date: September 23, 2013**

This notice describes how PHI about you may be used and disclosed and how you can get access to this information.

## PLEASE REVIEW IT CAREFULLY.

*If you have any questions about this notice, please contact the Facility Privacy Officer (FPO) by dialing the main facility number at (303) 861-0808. E*ach time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your Protected Health Information (PH)I created in the doctor's office or clinic.

**Our Responsibilities**
We are required by law to maintain the privacy of your PHI, provide you a description of our privacy practices, and to notify you following a breach of unsecured PHI. We will abide by the terms of this notice.

## Uses and Disclosures

**How we may use and disclose PHI about you.**
The following categories describe examples of the way we use and disclose PHI:

**For Treatment:** We may use PHI about you to provide you treatment or services. We may disclose PHI about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share PHI about you in order to coordinate the different things you may need, such as lab work, prescriptions, meals, and x-rays. We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

**For Payment:** We may use and disclose PHI about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Operations:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine PHI about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine PHI we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of PHI to protect your privacy.

**Fundraising:** We may contact you to raise funds for the facility. You have the right to elect not to receive such communications. We may also use and disclose PHI:

- To remind you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your PHI, however, business associates are required by federal law to appropriately safeguard your information.

**Directory:** We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (e.g., good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or FPO.

**Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes:** We may release health info about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

**Research:** The use of PHI is important to develop new knowledge and improve medical care. We may use or disclose PHI for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

**Future Communications:** We may communicate to you via newsletters, mail or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

**Organized Health Care Arrangement:** This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to PHI in their offices to assist in reviewing past treatment as it may affect treatment at the time.

**Affiliated Covered Entity:** PHI will be made available to facility personnel at local affiliated facilities as necessary to provide treatment, payment and health operations. Caregivers at other facilities may have access to PHI at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the FPO for further information on the specific sites included in this affiliated covered entity.

**PHI Exchange/Regional PHI Organization:** Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your PHI with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

**As required by law.** We may disclose information when required to do so by law. **As permitted by law,** we may also use and disclose PHI for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

**Law Enforcement:** We may disclose PHI to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

**For Judicial or Administrative Proceedings:** We may disclose PHI as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

**Authorization Required:** We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes, or to sell your PHI.

**State-Specific Requirements:** Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

**Your PHI Rights**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- ***Inspect and Copy:*** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- ***Amend:*** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information sept by or for the facility. Any request for an amendment must be sent in writing to the FPO. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- ***An Accounting of Disclosures:*** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your PHI for purposes other than treatment, payment or health care operations where an authorization was not required.
- ***Request Restrictions:*** You have the right to request a restriction or limitation on PHI we use or disclose about your treatment, payment or health care operations. You have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, e.g. a family member or friend. For example, you could ask to not disclose information about a surgery you had. Any request for a restriction must be sent in writing to the FPO.
- We are required to agree to your request ***only*** if: 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- ***Request Confidential Communications:*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- ***A Paper Copy of This Notice:*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

**Changes to This Notice -** We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

**Complaints** - If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

**OTHER USES OF PHI -** Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

**Please contact the Facility Privacy Officer at 303.861.0808**