GATEWAY FOOT&ANKLE CENTER

Dr. David E. Smith, DPM, FAPWCA, AACFAS, FACFAOM
Dr. Matthew D. Truscello, DPM, FACFAOM
647 Dunlop Lane, Suite 209
Clarksville, TN 37040
PH (931) 245-1920
Fax (931) 245-1929

Welcome to Gateway Foot & Ankle Center

Thank you for choosing us for all of your foot and ankle needs. We are dedicated to providing you with quality care in a very friendly, professional atmosphere. Please read carefully and sign at the bottom indicating your understanding and acceptance of our policies and procedures.

General, Financial and Insurance Polices – Effective August 1, 2016

General Practice Policies

- Please give us at least 24 hours advanced notice if you need to cancel or reschedule your appointment. **All appointments that are canceled or rescheduled **without** 24 hour notice are subject to a $50.00 fee.*
- If your insurance requires a referral, it is your responsibility to keep track of the number of visits and request additional visits from your primary care physician if needed.

Financial Policy

- **Patients are responsible for all co-payments, un-met deductibles and any outstanding balance due on their accounts at the time of service.** There is a $25.00 charge for all returned checks.
- Payment for any non-covered podiatry supplies or procedures will be collected at the time of service.
- **Surgery:** A **$250.00 fee** will be assessed in the event you no-show or do not cancel/reschedule your surgery with at least 48 hours notice.
- **Forms:** There is a basic fee of $20.00 for each form we complete for you. Lengthy forms, letters, or paperwork may be subject to a higher fee.

Insurance

- We file your insurance as a courtesy to you. If we are not a provider with your insurance you will be responsible for the total cost of the office visit and any procedures performed at the time of service.
- You are responsible for keeping up with your benefits that your insurance provides. In the event that your insurance denies your claim for any reason, you will be responsible for all services rendered.

Thank you again for choosing our office.

Please Sign and date below indicating that you understand and accept our policy.

_____ _____

Print Patient Name Date

_____

Signature

GATEWAY FOOT&ANKLE CENTER

David E. Smith, DPM, FAPWCA, FACFAOM
Matthew D. Truscello, DPM, FACFAOM
647 Dunlop Lane, Suite209
Clarksville, TN 37040

Pediatric Patient Registration Form

In order to serve you properly, we will need the following information. All information is strictly confidential.

Please complete in BLACK or BLUE Ink ONLY.

How did you hear about Gateway Foot and Ankle Center? _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Date of Birth: _____ Age: _____ Sex: Female ☐ Male ☐
Race: _____ Ethnic Group: _____ Preferred Language: _____
Home Phone #: _____ Cell Phone #: _____ Email: _____
May we leave messages at your home and/or cell number(s)? _____
Preferred contact method (circle)? Cell Home Work Mail Email Other (Please Specify): _____
Emergency Contact Name: _____ Relationship _____ Emergency Phone #: _____

GUARANTOR/GUARDIAN INFORMATION:

First Name: _____ Last Name: _____ DOB: _____ SS#: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
Address (if different from above): _____ City: _____ State: _____ Zip: _____ Person responsible for any bills incurred beyond insurance: Mother Father Other _____

MEDICAL INFORMATION:

Referring Physician: _____ Address: _____
Phone #: _____ Fax #: _____
Pharmacy: _____ Phone #: _____
Is the child here as a result of an auto accident? YES NO

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance: _____ Policy / ID #: _____
SSN: _____ Date of birth: _____
Secondary Insurance: _____ Policy / ID #: _____
SSN: _____ Date of birth: _____

Please read all the information below and then sign and date this form.

I consent to treatment and request that payment of authorized Medicare/Commercial Insurance benefits be made to your provider at Gateway Foot & Ankle Center for any services furnished by that physician and his employees. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent or to my insurance company any information needed to determine these benefits payable for their related services.

I acknowledge full financial responsibility for all services rendered by your provider and the employees at Gateway Foot and Ankle Center and understand that payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of charges that I incur.

Signature: _____ **Date:** _____

GATEWAY FOOT&ANKLE CENTER

Please complete in BLACK or BLUE Ink ONLY.

WHAT IS THE REASON YOU ARE BEING SEEN AT GATEWAY FOOT & ANKLE CENTER TODAY?

_____

_____

_____

_____

PRIMARY PHYSICIAN'S NAME AND ADDRESS:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

OTHER PHYSICIAN'S NAME AND ADDRESS:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Height: _____ **feet** _____ **inches** **Weight:** _____ **lbs.**

SYSTEMS REVIEW: (CHECK ALL THAT YOU HAVE HAD IN THE PAST 6 WEEKS)	CHECK BOX IF NONE OF THE BELOW APPLY ☐			
General:	☐ Chills	☐ Fatigue	☐ Fever	☐ Weight Change(loss or gain)
Eyes:	☐ Blurred Vision	☐ Eye Pain	☐ Sensitive to light	
Ears/Nose/Throat:	☐ Ear pain	☐ Congestion	☐ Hoarseness	☐ Dental problems
	☐ Runny nose	☐ Nosebleeds	☐ Hearing Problems	
Cardiovascular:	☐ Edema	☐ Chest pain	☐ Palpitations	☐ Rapid heartbeat ☐ Short of breath lying down
Respiratory:	☐ Cough	☐ Shortness of breath	☐ Coughing up blood	
Gastrointestinal:	☐ Heartburn	☐ Abdominal pain	☐ Diarrhea	☐ Constipation ☐ Stool Changes
Hematologic/Lymphatic:	☐ Easy bruising	☐ Bleeding	☐ Enlarged lymph nodes	
Genitourinary:	☐ Blood in urine	☐ Painful urination	☐ Frequent urination	
Musculoskeletal:	☐ Joint pain	☐ Back pain	☐ Muscle pain	
Integumentary (Skin):	☐ Dry skin	☐ Rashes	☐ Fungal nail infection	☐ Warts
Neurological:	☐ Dizziness	☐ Headaches	☐ Weakness	☐ Numbness
Endocrine:	☐ Hair loss	☐ Excessive thirst	☐ Excessive hunger	☐ Heat/Cold Intolerance
Psychiatric:	☐ Anxiety	☐ Depression	☐ Sleep disturbance	

SOCIAL HISTORY:

With whom do you live with? _____

Highest Level Education Completed: _____

Employment/Occupation: _____

Tobacco: ☐ YES ☐ NO How long? _____ How many packs per day? _____

If NO did you ever smoke? ☐ YES ☐ NO If so, how long? _____ Quit Date: _____

Alcohol: ☐ YES ☐ NO If so, how much? _____

FAMILY HISTORY (PLEASE LIST ALL FAMILY REQUESTED, IF APPLICABLE, NAMES NOT REQUIRED): ☐ **UNKNOWN, ADOPTED**

	AGE:	MAJOR ILLNESS(S):	IF DECEASED, CAUSE OF DEATH:
Father:			
Mother:			
Brother(s):			
Sister(s):			

	AGE:	SEX:	MAJOR ILLNESS(S):	IF DECEASED, CAUSE OF DEATH:
Children:				

Patient Name: _____ DOB: _____

Please complete in BLACK or BLUE Ink ONLY.

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY)

CHECK HERE IF NONE APPLY ☐

Gastrointestinal: ☐ Irritable Bowel Syndrome ☐ Pancreatitis ☐ Hepatitis ☐ Crohn's Disease	☐ GERD ☐ Peptic Ulcer Disease ☐ See: Other Information	**Pulmonary:** ☐ Pulmonary Embolism ☐ COPD ☐ Pneumonia	☐ Asthma ☐ Sleep Apnea ☐ See: Other Information
Cardiovascular: ☐ Congestive heart failure ☐ Heart Attack (MI) ☐ Deep Venous Thrombosis (DVT) ☐ Hypertension ☐ Coronary Artery Disease	☐ Arrhythmia ☐ Hyperlipidemia ☐ Peripheral Vascular Disease ☐ Mitral Valve Disease ☐ See: Other Information	**Renal/Genitourinary:** ☐ Renal Failure/Disease ☐ Urinary Incontinence ☐ Bladder disease ☐ BPH (Benign Prostatic Hypertrophy)	☐ Renal Stones ☐ Ovarian Disease ☐ Kidney Disease ☐ See: Other Information
Musculoskeletal: ☐ Fibromyalgia ☐ Chronic pain ☐ Gout ☐ Lupus	☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fractures ☐ See: Other Information	**Endocrine:** ☐ Diabetes type II ☐ Hyperthyroidism ☐ Hypothyroidism ☐ See: Other Information	
Immunology/Dermatology: ☐ Allergies ☐ Eczema ☐ Immunodeficiency	☐ Psoriasis ☐ Sinusitis (frequent) ☐ See: Other Information	**Hematologic:** ☐ Anemia ☐ HIV (AIDS) ☐ Blood clots	☐ See: Other Information
Neurological/Genetic: ☐ Alzheimer's disease ☐ CVA ☐ Dementia ☐ Headaches ☐ Seizure Disorder	☐ Parkinson's disease ☐ Down Syndrome ☐ Multiple Sclerosis ☐ See: Other Information	**Cancers:** ☐ Bone Cancer ☐ Lymphoma ☐ Prostate Cancer ☐ Lung Cancer ☐ Skin Cancer: Type_____ ☐ Location_____	☐ Pancreatic Cancer ☐ Renal Carcinoma ☐ Testicular Cancer ☐ Thyroid Cancer ☐ See: Other Information
Other/Misc.: ☐ Cataract ☐ Glaucoma ☐ See: Other Information	☐ Drug Abuse ☐ Alcoholism		

*OTHER INFORMATION: _____

_____

_____

SURGICAL HISTORY: (CHECK and CIRCLE ALL THAT APPLY)

CHECK HERE IF NO SURGICAL HISTORY ☐

☐ Appendectomy	☐ Cardiac Valve Replacement	☐ Arthroscopy: Location_____
☐ Tonsillectomy	☐ Hysterectomy (partial/total)	☐ Biopsy: Type _____
☐ Adenoidectomy	☐ Cataract Removal (right/left)	☐ Joint Replacement: Location_____
☐ Hernia repair	☐ Cholecystectomy (gall bladder removed)	☐ Fracture: Location_____
☐ Thyroidectomy	☐ Coronary Angioplasty	☐ Leg Bypass Surgery: Location_____
☐ Prostatectomy	☐ Pacemaker Implantation	☐ Leg Stent Placement: Location_____
☐ Coronary Artery Stent	☐ CABG (Coronary Artery Bypass Graft)	☐ See: Other Information

*OTHER INFORMATION: _____

_____

_____

ANYTHING WE DID NOT ASK THAT YOU THINK WE SHOULD KNOW ABOUT. _____

_____

Patient Name:_____ DOB: _____

GATEWAY FOOT&ANKLE CENTER

Please complete in BLACK or BLUE Ink ONLY.

Name: _____ Date: ___/___/___

Date of birth: _____

MEDICATION AND ALLERGY LIST

Please list all medications you are currently taking, including vitamins, herbs, and natural supplements or Check None box below and sign at the bottom.

☐ NO MEDICATIONS

NAME	DOSAGE	HOW OFTEN

Please list all allergies or check box if no known drug allergies. ☐

Patient Signature: _____ Date: _____/_____/_____

GATEWAY FOOT&ANKLE CENTER

GATEWAY FOOT&ANKLE CENTER

David E. Smith, DPM, FAPWCA, FACFAOM
Matthew D. Truscello, DPM, FACFAOM
647 Dunlop Lane, Suite209
Clarksville, TN 37040
Ph: (931)245-1920 Fax: (931) 245-1929

Patient Portal User Agreement

Patient Portal is a secure web portal that allows you, as a patient, to access certain electronic medical records. It can also be used to communicate with clinic staff directly via a secure messaging system. When using Patient Portal you have the opportunity to:
*View and print medication lists, allergies, lab/diagnostic results, and any pertinent medical history
*Request corrections to be made to demographic information
*Get answers to *non-emergency* questions
*Request/confirm/reschedule/cancel appointments online (although we are offering this service at this time, the best way to get the appointment you want, when you need it, is to give our office a call.)
*Request refills on medications

Please read the following policy carefully:
*We do not sell or give away any private information including email addresses, without your written consent, please read our HIPPA policy form for more information about private health information.
*We are offering Patient Portal as a courtesy to our established patients, however, if abuse or negligent usage of the portal persists, we reserve the right at our own discretion to suspend or terminate user access or modify services offered through Patient Portal as well as the right to discontinue its use.
*Since Patient Portal communicates with our staff through our electronic medical records, *it is only monitored during normal business hours*. It is unlikely we will "see" any messages sent after hours or on weekends. We will make every attempt to return portal messages within 1-3 business days starting on the date after the message was sent. Please do NOT use the portal for emergencies or urgent matters. You must call our office at (931) 245-1920 if you have an urgent matter to discuss.
*If you are not receiving emails from us, please check your JUNK or SPAM folder before contacting our office.
*By using the Patient Portal, you agree to protect your password from unauthorized individuals. It is your responsibility to notify us in the event that your password is stolen. You agree to not hold Gateway Foot and Ankle Center responsible for any network infractions beyond our control.

Please remember that Patient Portal is a relatively new feature of electronic records, and as such, runs the risk of having some imperfections. Feel free to browse your Patient Portal and get acquainted with the features it has to offer. We, at Gateway Foot and Ankle Center, welcome the opportunity to offer you personalized care.

Name: _____

- ☐ Yes, I would like to use the Patient Portal
- ☐ No, I decline use of the Patient Portal or do not have an email address at this time

Signature: _____ **Date:** _____

Email Address (required for use): _____

By signing this consent you are activating your Patient Portal. A message will be sent to the email address provided with instructions on how to create your log in information. For further instructions see the "Portal Instructions for the Patient," information sheet. Your Patient Portal User Agreement is valid for 12 months. At the end of 12 months an email will be sent to you to re-register your account. If the log in is not re-registered it will be considered inactive.

GATEWAY FOOT&ANKLE CENTER

HIPPA Regulations Privacy Documents

(Patient signature required at the bottom.)

I, _____, hereby authorize Gateway Foot & Ankle Center to use and/or disclose my health information which specifically identifies me or which can be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent Gateway Foot & Ankle Center can refuse to treat me. I also grant permission to obtain a check of my medication history from all pharmacies and providers for medical reconciliation purposes.

I have notified that the Notice of Privacy Practices is available on request and also located in the waiting room of Gateway Foot & Ankle Center which contains a more complete description of the uses and disclosures of my protected information. I understand that this practice has the right to change the Notice of Privacy Practices periodically and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy.

I understand that I may request in writing that Gateway Foot & Ankle Center, restrict how my protected information is used and disclosed to carry out treatment, payment or health operations. I also understand that my provider is not required to agree with my request, but if this practice does not agree then I am bound to abide by written restriction.

I, _____, hereby give written consent to Gateway Foot & Ankle Center to disclose my protected health information including treatment, payment, and health care operations with the following person(s):

_____

Last Name **First Name** **Relationship to Patient**

_____

Address **City** **State** **Zip**

_____

Last Name **First Name** **Relationship to Patient**

_____

Address **City** **State** **Zip**

X_____

Signature of patient or patient's representative ***Date***

_____

Printed name of patient or patient's representative

_____

Relationship to patient

~~THIS FORM IS FOR YOU TO LIST FAMILY MEMBERS OR TRUSTED FRIENDS WHO YOU GIVE CONSENT TO TALK WITH YOUR~~ PROVIDER OR TO PICK UP YOUR MEDICAL RECORDS IF YOU ARE UNABLE TO. IF YOU DO NOT LIST ANYONE, THEY CANNOT TALK WITH YOUR PROVIDER ABOUT YOUR CARE AND THEY WILL BE UNABLE TO PICK UP ANY MEDICAL RECORDS OR ANY OTHER PAPERWORK FOR YOU.

**PATIENT SIGNATURE REQUIRED

GATEWAY FOOT&ANKLE CENTER

David E. Smith, DPM, FAPWCA, FACFAOM
Matthew D. Truscello, DPM, FACFAOM
647 Dunlop Lane, Suite 209
Clarksville, TN 37040
Phone: (931) 245-1920
Fax: (931) 245-1929

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. This information is referred to as "protected health information" or PHI. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI

Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We serve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

!. Treatment Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood, or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment Our practice may use and disclose your PHI in order to bill and collect payment for the services and items that you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay, for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

OPTIONAL:

5. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

6. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

7. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

8. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to a pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

C. USE AND DICLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individual s if a product or device they be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures and actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the healthcare system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the requestor to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain n the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to

GATEWAY FOOT&ANKLE CENTER

David E. Smith, DPM, FAPWCA, FACFAOM
Matthew D. Truscello, DPM, FACFAOM
647 Dunlop Lane, Suite 209
Clarksville, TN 37040
Phone: (931) 245-1920
Fax: (931) 245-1929

reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. Military. *Our practice* may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

OPTIONAL:

10. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

11. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

12. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or discloser involves no more than a minimal risk to your privacy based on the following: (A)an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or discloser would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (III) the research could not practicably be conducted without access to and use of the PHI.

D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care, such as family members and friends. **We are not required to agree to your request;** however, if we do not agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

a) The information you wish restricted
b) Whether you are requesting to limit our practice's use, disclosure or both; and
c) To whom you wants the limits to apply

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor an supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is correct or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us for a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the cost involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Private Officer.

7. Right to File a Complaint If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable Law. Any authorization you provide to us regarding the use and discloser of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records for your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.

For questions regarding this notice, please contact Lauree at Gateway Foot & Ankle Center.
(931) 245-1920