FAMILY MEDICAL CLINIC
BECAUSE YOUR HEALTH WON'T WAIT

Pediatric Registration

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Gender: ☐ M ☐ F

I am currently a patient at (check all that apply): ☐ FMC Heartwise ☐ FMC – Interventional Pain

Home Phone #:	Work Phone #:	Cell Phone #:
OK to leave message: ☐ YES ☐ NO	OK to leave message: ☐ YES ☐ NO	OK to leave message: ☐ YES ☐ NO

Mailing Address:

City:	State:	Zip Code:

Physical Address (if different from above):

Type of Residence where you live: ☐ Home ☐ Shelter ☐ Homeless ☐ Friends/Family ☐ Transitional ☐ Other_____ Number of people in the household:_____

Race: ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Native Hawaiian ☐ More than one race:_____ ☐ Asian ☐ White/Caucasian ☐ Other Pacific Islander

Are you of Hispanic or Latina origin: ☐ Yes ☐ No

Language most comfortable with: ☐ English ☐ Other: (Please list)_____ Do you need a translator? ☐ No ☐ Yes

Emergency Contact Name:	Relationship to Patient:

Emergency Phone: ☐ Work #: ☐ Home #: ☐ Other #:

Preferred Pharmacy:

Responsible Party:	Date of Birth:	Social Security #:	Relationship to Patient:

Mailing Address:

Home Phone #:	Work Phone #:	Cell Phone #:
OK to leave message: ☐ YES ☐ NO	OK to leave message: ☐ YES ☐ NO	OK to leave message: ☐ YES ☐ NO

Responsible Party Occupation (if employed):	☐ N/A ☐ Student	Employer:

My signature here indicates the information provided above is true and correct.

Signature *(Responsible Party)* *Date*

Print Name *(Responsible Party)* *Date*

Please complete back page of Registration

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**** We bill insurance as a courtesy. Please supply us with a copy of your insurance card(s) as well as the following information. ****

INSURANCE COVERAGE: ☐ None ☐ Alaska Medicaid ☐ Denali KidCare ☐ Medicare ☐ Private Insurance ☐Other:

Primary INSURANCE Company:	Policy / ID #:	Group #
Last Name of Insured:	First:	M.I.
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependant ☐ Other:		
Date of Birth:	SSN:	Gender: ☐ M ☐ F
Mailing Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Employer:	

Secondary INSURANCE Company:	Policy / ID #	Group #
Last Name of Insured:	First:	M.I.
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependant ☐ Other:		
Date of Birth:	SSN:	Gender: ☐ M ☐ F
Physical Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Employer:	

We bill insurance as a courtesy, by signing below you are authorizing FMC to perform the necessary requirements to do so.

Authorization to pay benefits to FMC: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to FMC, when they accept assignment. My signature here indicates the information provided above is true and correct.

Signature *(Responsible Party)* *Date*

Print Name *(Responsible Party)* *Date*

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Service Agreement

Patient Name: _____ Date of Birth: _____

In order to receive treatment, you must sign below acknowledging the following terms. Please ask questions about any area of concern.

Service Agreement

- ☐ Family Medical Clinic (FMC) offers health care using a team of caregivers. These people have various training and skills which they utilize while working together as a team to help meet your health care needs. FMC has an integrated electronic health record system. Personal Health Information (PHI) is kept in your electronic health record. Your records are accessed by FMC staff members who are involved in your care. Your records may include information from any of our medical providers. It may also include reports from caregivers elsewhere, when you are referred by FMC staff to other agencies for health care services.
- ☐ All health information is kept private between you and your health care professional except in circumstances when disclosure is required or otherwise permitted by law.
- ☐ It is your responsibility to keep your scheduled appointments. If you cannot make the scheduled appointment time, you should call to reschedule your appointment in accordance with our *Appointment Policy* which is provided on the following page.

Privacy Agreement

- You have been offered a copy of FMC's *Notice of Privacy Practices*. A copy of FMC's *Notice of Privacy Practices* is posted at each service location. FMC takes seriously the protection of your Personal Health Information (PHI) and will only divulge minimum necessary information required to accomplish our purpose.
- ☐ You may register a complaint or voice a grievance without fear of reprisal.
- You have been offered a copy of FMC's *Patient Bill of Rights*.

Financial Responsibility

- All services are billed at a standard rate. **FMC bills insurance as a courtesy.** You are responsible for the balance not covered by insurance or third party payers within 120 days of your service. If you qualify, a sliding-scale discount may be applied to the unpaid balance or any "out-of-pocket" expenses. Discounts are available based on household size and household income.
- ☐ You agree to pay your fees and/or insurance co-payment and required deductible at the time of service. Any balance on your account after 120 days will be sent to Cornerstone Collections. FMC accepts assignment on Medicare and Medicaid claims.
- FMC does not operate a "free clinic." Regardless of insurance coverage or financial category, you will not be refused services because of an inability to pay, as long as you agree to demonstrate a willingness to pay. **Unwillingness to pay your account balance within 120 days will result in the balance being sent to Cornerstone Collections and may result in your dismissal as a patient**. You authorize a collections agency to contact you directly on your past balance due to Family Medical Clinic.
- ☐ If you fail to provide income verification or proof of insurance, or choose not to use your insurance, you will not be eligible to participate in a sliding discount and will be responsible for 100% of the charges for services rendered by FMC providers.
- ☐ FMC relies on the fees paid by you and your insurance company to continue to deliver services.

****I have read and agree to the above**
Service Agreement, Privacy Agreement and Financial Responsibility.**

Signature (Patient or Responsible Party): _____ Date _____

Print Name (Patient or Responsible Party): _____ Date _____

Appointment Policy

Patient Name: _____ ***DOB:*** _____

We see patients on an appointment basis and your appointment is reserved exclusively for you. We respect your time and make every effort to remain on schedule; therefore we must request that you check-in on time for your appointment. Arrival time is based on appointment type and is determined by each department. Expected arrival time is communicated to you when you book your appointment.

We understand that circumstances arise that prevent patients from keeping appointments. If you are not able to keep a regular doctor appointment, please call and cancel or reschedule by 3 pm the day before your scheduled appointment. If you do not there will be a $25.00 no show/cancellation fee that will be charged to you.

If you are unable to keep a FMC – Heartwise appointment, you must call 48 hours in advance to cancel or reschedule. If you do not there is a $250 no show/cancellation fee that will be charged to you.

If you are unable to keep a FMC – Interventional Pain appointment, please call and cancel or reschedule by 3 pm the day before your scheduled appointment. If you do not there will be a $25.00 no show/cancellation fee that will be charged to you. If you are unable to keep an appointment with a Specialized Doctor, you must call 48 hours in advance to cancel or reschedule. If you do not there is a $250 no show/cancellation fee that will be charged to you.

We request these accommodations from you as it allows us to see our patients promptly as well as have time to fill cancelled appointment slots. Effective December 1, 2016 our policy states that once a second scheduled appointment is missed within a 12 month period, a notice will be sent alerting you of the consequence of missing the third scheduled appointment within a 12 month period. The consequence is that you (the patient) will only be seen on a same day appointment (if available) for the FMC – Family Practice and FMC – Heartwise. ***Due to the pain contract in FMC – Interventional Pain three missed appointments will be a termination and you will not be seen in any FMC department for 12 months.***

Patients are required to check-in at the clinic at the recommended check-in time. Patients checking-in after the recommended check-in time are considered late and will be seen only if the provider's schedule and remaining time allows for the completion of quality care.

ATTENTION PARENTS AND GUARDIANS: If your child is under 18, the policy requires that you accompany your child to all appointments and remain in the clinic during his/her appointment. Treatment will not begin until a parent or guardian is present.

I have read and understand the above appointment policy for Family Medical Clinic.

_____ _____

Signature (Patient or Responsible Party) Date

Pediatric Patient History Form

FAMILY MEDICAL CLINIC
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Patient Name: _____ **DOB:** _____

Provider: _____ **Visit Date:** _____

Past Medical History:

Any Complications with Pregnancy?	☐ Yes ☐ No
Details:	
Birth Weight: Born on Time? ☐ Yes ☐ No	If No, how early/late?

Childhood Illnesses:

☐ Allergies ☐ Asthma ☐ Bronchitis ☐ Chicken Pox ☐ Diabetes ☐ Eczema
☐ Ear infections ☐ Elevated Cholesterol ☐ Tonsillitis ☐ Other:
☐ Hospitalized; Reason:

Allergies	**Reaction**

Current Medications: (include "Over-the-Counter" such as aspirin, ibuprofen, vitamins, etc)

Medication Name	Route (Topical, Oral, etc.)	Dosage	Frequency	Duration

Vaccinations:

Is patient up-to-date on vaccinations?	☐ Yes ☐ No

****Please vaccination records to medical assistant or nurse****

Surgical History:

Date	Procedure

Family History:

Family Member	Status *Alive / Deceased / Unknown*			DOB	Medical Problems
Father	*A*	*D*	*UnK*		
Mother	*A*	*D*	*UnK*		
Father's Father	*A*	*D*	*UnK*		
Father's Mother	*A*	*D*	*UnK*		
Mother's Mother	*A*	*D*	*UnK*		
Mother's Father	*A*	*D*	*UnK*		

Social History:

Grade in school?

Does anyone in the household smoke? ☐ Yes ☐ No	**Any second hand smoke exposure?** ☐ Yes ☐ No

Does anyone in the household use drugs other than prescribed by a medical provider? ☐ Yes ☐ No

Who lives at home?

Is there any history of exposure to domestic violence? ☐ Yes ☐ No

Do you use a car seat regularly? ☐ Yes ☐ No

PATIENT BILL OF RIGHTS & RESPONSIBILITIES

FAMILY MEDICAL CLINIC

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Our patients have the right to…

1. receive service without regard to age, race, color, sexual orientation, religion, marital status, gender, national origin or sponsor;

2. be treated with consideration, respect and dignity including privacy in treatment;

3. be informed of the services available and the name and function of person providing health care services;

4. receive from your health care provider information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed consent shall include, at a minimum:
   - information concerning the procedure or treatment or both;
   - the reasonably foreseeable risks;
   - alternatives for care or treatment, if any, as a reasonable provider under similar circumstances would disclose;

5. be informed of off-hour emergency coverage;

6. be informed of the charges for services, assistance in determining eligibility for third-party reimbursements and, when applicable, informed of the availability of discounted cost care;

7. receive an itemized copy of your bill upon request;

8. obtain from your health care provider, or their delegate, complete and current information concerning your diagnosis, treatment and prognosis in terms you can be reasonably expected to understand;

9. voice grievances and recommend changes in policies and services to FMC staff, administration, and the Alaska State Department of Health without fear of reprisal;

10. express complaints about the care and services provided and to have such complaints investigated. FMC is responsible for providing a written response within 30 days, if requested, indicating the findings of the investigation. FMC is also responsible for notifying you or your designee that if you are not satisfied with the response, you may register a complaint to the Alaska State Department of Health & Human Services Office, by phone (907)465-4722 or at www.hss.state.ak.us,

11. appoint someone you trust to decide about your treatment, if you lose the ability to decide for yourself;

12. receive care in an environment where pain and/or suffering can be expressed with comfort and dignity;

13. access or amend your health record as allowed by privacy laws;

14. privacy and confidentiality of all information and records pertaining to your treatment;

15. approve or refuse the release or disclosure of contents of your health record except as required or allowed by law.

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The patient or their legally designated representative is responsible…

1. to actively participate in their care to the fullest extent possible;

2. to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health;

3. to make it known whether they clearly understand a suggested course of action and what is expected of them;

4. to follow the treatment plan recommended by the health care provider. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the health care providers orders;

5. to report unexpected changes in their condition to their provider;

6. to keep appointments and, when unable to do so for any reason, to follow the terms of the appointment policy;

7. for their actions if they refuse treatment or do not follow provider instructions. If the patient cannot follow through with the treatment, they are responsible for informing the health care provider;

8. for assuring that the financial obligations of their health care are fulfilled as promptly as possible. You are responsible for providing information needed by FMC to secure payment;

9. for following clinic rules and regulations affecting patient care and conduct;

10. for being considerate of the rights of other patients and personnel;

11. for being respectful of the property of FMC and others;

12. for recognizing the effect of lifestyle on your health which depends not just on the care you receive but on the decisions you make in your daily life;

13. for assuring that children brought into a FMC facility by you are supervised at all times.

FMC – Family Practice
(907) 262-7566

FMC – Heartwise
(907) 262-7566

FMC – Interventional Pain
(907) 260-1619

FAMILY MEDICAL CLINIC

BECAUSE YOUR HEALTH WON'T WAIT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical information is Protected Health Information (PHI) about you, including demographic information, that may identify you and that relates to your past, present and future physical, dental or behavioral health and related health care activities. We understand that your PHI is personal. We are committed to protecting your PHI and to sharing the minimum necessary information required to accomplish each purpose or disclosure. We create a record of the care and services you receive through Family Medical Clinic (FMC). This notice applies to all of your PHI that we have collected while caring for you at our agency.

This Notice of Privacy Practices describes how we are allowed to use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law (see in the body of the Notice). The Notice also describes your right to access and control your PHI.

I. USES AND DISCLOSURES OF PHI WITHOUT YOUR AUTHORIZATION

We use and disclose your PHI for treatment, payment, and healthcare operations. This privacy notice about PHI includes your physical health services information collected by the staff and providers of FMC.

A. **Treatment**: We may use or disclose your physical PHI to provide, coordinate or manage your healthcare services at FMC. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

B. **Payment**: We may use and disclose your dental, behavioral health and physical PHI to obtain payment for services we provide to you. Information that may be shared includes, but is not limited to: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. For example if you have health insurance and we bill your insurance directly, we will include information that identifies you, as well as your diagnosis, the procedures performed, and supplies used so that we can be paid for the treatment provided.

C. **Healthcare Operations**: We may use and disclose your dental, behavioral health and physical health information for our healthcare operations to support the business activities of FMC. 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, and conducting or arranging for other business activities.

1. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract, Business Associate and Qualified

Service Organization Agreement, which contains terms that will protect the privacy of your protected health information.

2. We may use basic demographic information limited to your name, date of birth, address, phone number, health insurance status, and the dates you received services, department of service information, treating provider information, and outcome information to contact you for fundraising activities. We will not prohibit or condition treatment of payment on whether you choose to receive fundraising communications. We raise funds to expand and support healthcare services, education programs, etc. We will not sell, trade, or loan your information to any third parties. You have the right to request not to receive this information. If you do not want to receive these materials, please contact our Compliance Officer and request that these fundraising materials not be sent to you.

3. We may contact you to remind you about appointments, test results, inform you about treatment options or advise you about other health-related benefits.

D. Other Use and Disclosures

We also use and disclose your information to enhance healthcare services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise allows by law. For example we provide or disclose information:

1. **Abuse, Neglect or Domestic Violence**: We may disclose your PHI 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 PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. We will make this disclosure only when specifically required or authorized by law or when you agree to the disclosure.

2. **Health Oversight Activities:** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your PHI if you are subject of an investigation and your PHI is not directly related to your receipt of health care or public benefits. In accordance with 7 ACC 71.400 – 7 ACC 71.449, we will disclose PHI to DMHDD for health oversight activities specifically identified in Alaska law.

3. **In Connection with Judicial and Administrative Procedures:** We may disclose your PHI in the course of any judicial or administrative proceedings in response to an order of a court or magistrate as expressly authorized by such order or in response to a signed authorization.

4. **Law Enforcement Purposes:** We may disclose PHI to a law enforcement official as required by law.

5. **Coroners, Medical Examiners, and Funeral Directors**: We may disclose PHI to a Coroner or Medical Examiner and Funeral Directors as authorized by law.

6. **Imminent Threat to Health or Safety:** Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

7. **To a Designated Hospital In the Event of an Involuntary Commitment:** We may disclose your protected medical health PHI to assure continuity of care.

8. **Specialized Government Functions**: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may

disclose PHI to correctional institution or law enforcement official having lawful custody of inmate or patient under certain circumstances.

9. **Natural Disaster:** We may use or disclose your location and general condition to an authorized public or private entity (such as FEMA or the Red Cross) authorized by its charter or by law to assist in disaster relief efforts.

10. **For Research Purposes:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

II. Other Uses and Disclosures When You Have an Opportunity to Object

A. To Your Family or Friends: Unless you object, your healthcare provider will use his or her professional judgment to provide relevant protected health information to your family member, friend, or another person. This person would be someone that you indicate has an active interest in your care or the payment for your healthcare or who may need to notify others about our location, general condition, or death.

B. Others Involved In Your Healthcare: We may use or disclose PHI 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 PHI, we will provide you with an opportunity to object to the use or disclosure.

C. Natural Disaster: We may use or disclose your location and general condition to an authorized public or private entity (such as FEMA or the Red Cross) authorized by its charter or by law to assist in disaster relief efforts.

D. In a Medical or Psychological Emergency: If you are incapacitated or in an emergency, we will disclose PHI using our professional judgment, only PHI that is directly relevant to the person's involvement in your healthcare. If this is a behavioral health concern, the contact will occur if you are a danger to yourself or others, or you are unable to meet your basic needs. We will also use our professional judgment and experience with common practice to make reasonable accommodation in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

E. Deceased Individuals: We may disclose to a family member, or other persons who were involved in an individual's care prior to the individual's death, PHI of the individual that is relevant to such a person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to PCHS.

III. Substance and Alcohol Abuse Diagnosis or Treatment

A. Substance Abuse Diagnosis or Treatment. If you have applied for or been given a diagnosis or treatment for alcohol or drug abuse, or a dual diagnosis involving alcohol or drug abuse, then there may be additional confidentiality protections applicable to your PHI under the federal regulations at 42 CFR Part 2.

IV. Use and Disclosure Requiring Your Authorization

A. Other then the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. FMC requires your written authorization for marketing (other than face to face communication between you and a FMC staff member, a promotional gift of nominal value); or before we sell your protected health information. For all other disclosures of your PHI we must obtain a written authorization for release of information from you. 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. Other uses and disclosures not described in this notice will be made only with your authorization.

FAMILY MEDICAL CLINIC
BECAUSE YOUR HEALTH WON'T WAIT

V. Your Rights Regarding Protected Health Information

A. Access: You have the right to look at or get copies of your PHI, with limited exceptions. If we determine that providing you access to your record constitutes a danger to you or others, we can use our professional judgment regarding that access. You may request that we provide copies in a format other than photocopies. We will use the format you request if reasonably possible. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time.

B. Disclosure Accounting: You have the right to request a list of instances where we or our business associates, disclosed your PHI for reasons other than treatment, payment, healthcare operations and certain other activities. Your first accounting of disclosures is free of charge. Any additional request within additional requests within the same calendar year requires a processing fee.

C. Restriction: You have the right to request in writing restrictions on our use or disclosure of your PHI for treatment, payment or healthcare operations. We are not required to agree to additional restrictions but if we do agree, we must abide by those restrictions, except in an emergency situation or as required by law. If you make your request to the FMC Clinical Operations Manager, we will provide you with a written notice of our decision about your request.

D. Restriction on Certain Disclosures to Health Plans: You have a right to request a restriction on disclosures to a health plan for a health care item or service for which you, or a person other than the health plan on your behalf, has paid FMC in full. FMC must agree to this request, unless a law requires us to share that information.

E. Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at an alternative location. Your request must be in writing and specify the alternative means or location. Your request must specify how and where you wish to be contacted. We will accommodate reasonable requests.

F. Amendment: You have the right to request that we amend your PHI. Your request must be made to your provider, in writing, and it must explain why the information should be amended. We may deny your request and we will do so in writing. You have the right to file a statement of disagreement with us and we may prepare a response to your statement and will provide you with a copy of any response. It will be added to your medical record.

G. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive a paper copy of this Notice.

VI. Our Legal Duties

We are required by law to maintain the privacy of your protected health information, notify affected individuals following a breach of unsecured protected health information, provide this notice about our privacy practices, and follow the privacy practices that are described in this Notice.

VII. QUESTIONS AND COMPLAINTS

For more information about our privacy practices or have questions or concerns, please contact us. If you feel that we have violated your privacy rights you may complain to us using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may also contact the Office of Civil Rights to file a complaint. We will provide you with their address upon request.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may contact our Clinical Operations Manager at:
FMC - COM
Family Medical Clinic
206 W Rockwell Ave, Suite 100
Soldotna, Alaska, 99669
Phone: (907) 262-7566

VIII. Reservation of Right to Change this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will include on the bottom of every page the effective date. You will be offered a copy of the current notice when you visit our offices for services.

IX. Effective Date of this Notice of Privacy Practices

This Notice of Privacy Practices is effective 11/01/2016