Metabolic Health and Pain Management

26206 Willow Drive, Spring Hill, FL 34606 | (P) 352-659-6738 | (F) 352-606-5765

Thank you for choosing our facility for your health care. We ask that you have all the paperwork completed prior to your scheduled appointment. I ask to give ample time to fully read and fill out the required information to help Dr. Courtney with his assessment of you. WE CAN NOT see you unless the packet is completed.

If you show up without it completed, there will be a fee for this initial consultation time allocated, which is approximately 45 minutes of his time that is reserved for you. We do not double book our appointments. To help maintain a shorter waiting time we ask for your consideration and help to confirm your follow up appointment 48 business hours in advance or at the time of your visit.

Thank you for understanding and complying with us in advance.

Michael D. Courtney, M.D.
Board certified Pain/Anesthesia

Metabolic Health and Pain Management

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Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Home Address _____

Street _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Sex: [ ] M [ ] F

Email Address _____ Ethnicity _____

Social Security Number _____ Date of Birth _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widow [ ] Widower

Occupation _____ Employer _____

Primary Insurance _____ ID # _____

Secondary Insurance _____ ID # _____

Who referred you? _____

Spouse (or Guarantor)

Last Name _____ First Name _____ MI _____

Social Security Number _____ Date of Birth _____

Occupation _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contacts

Contact #1 _____ Phone _____ Relation _____

Contact #2 _____ Phone _____ Relation _____

Primary Care Physician _____ Phone _____

I understand that all the fees or changes because of my visit are payable at the time the professional services are rendered. I authorize my insurance carrier, if applicable, to pay for me. I agree to pay for all charges not covered by insurance when they are billed to me. I authorize the office to release to my medical insurance company, attorney or adjuster any information about my care here and to release all information about me pertaining to HIV status, substance abuse, or mental and nervous conditions, if any, should they request that information. Medical information may also be released to the billing agent to submit insurance claims for payment on behalf of the physician.

Date: _____ Signature: _____

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Patient Name: _____

Height: _____ft _____in Weight: _____ LBS Smoker: [ ] YES [ ] NO [ ] FORMER

ALLERGIES: [ ] PCN [ ] SULFA [ ] OTHER: _____

REACTIONS:

[ ] HIVES [ ] SWELLING OF TONGUE, LIPS, THROAT

[ ] RASH [ ] TIGHTNESS OF CHEST, THROAT

[ ] DECREASED BP [ ] DIFFICULTY BREATHING, SWALLOWING

[ ] ITCHING [ ] FLUSHING

Do you have an Epi-Pen? [ ] YES [ ] NO

MEDICATIONS YOU ARE TAKING:

NAME	MG/MCG	HOW OFTEN	AMOUNT PRESCRIBED

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Medical Record Release Authorization Form

I hereby authorize the release of my medical records inclusive to:

[ ] Pharmacy
[ ] Progress Notes (Last 4 Visits)
[ ] H & P
[ ] Radiology & Lab Reports (Most Recent Reports)
[ ] Any report required for treatment by Dr. Michael Courtney

Patient Signature: _____

Name (Please Print): _____

D.O.B.: _____ Phone #: _____ SSN: _____

**** REQUIRED** List All Doctors Involved in Your Care. Names & Phone #s Below**

Primary _____

Cardiologist _____

Psychiatry _____

Urologist _____

Dentist _____

GI _____

Surgeon _____

Last Pain Mgmt Physician _____

I understand the release is for medical purposes, and that information is kept private and confidential.

Thank you,
Dr. Michael Courtney, M.D.

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Narcotic Agreement with Policies and Procedures

The Purpose of this agreement is to prevent misunderstandings about medications that may be required for your pain problem. Whether you are a Chronic or Acute pain patient, this is to help both you and Dr. Courtney comply with the law regarding controlled medications:

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Dr. Courtney not providing ongoing care for me.

I, _____, agree to undergo pain management by Dr. Courtney and that my diagnosis is recorded in my chart.

I agree to the following statements:

1. I will NOT accept any narcotic prescriptions from another doctor involved in my care, IE: Dentist, Primary, Cardiologists, ER Doctors etc.

2. I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome, such as profuse sweating, nausea, vomiting, stroke, seizures, heart attack, possibly death.

3. I understand that I must keep my medications in a locked place safe from theft, I understand that Dr. Courtney will NOT supply additional refills for the prescriptions of medications that I may have lost or used to self-medicate with.

If your medications are stolen, Dr. Courtney will evaluate the situation and may or may not refill the prescription. *BEFORE* you call our office to inform the Dr. of stolen medication, you must call the police. A copy of the police report with the theft of prescribed medication noted in the report. Bring the police report to our office. A decision will be made after this is completed by you.

4. I will not give my narcotics to anyone else, nor "borrow medications". I agree to take the medications as prescribed by Dr. Courtney. I agree not to increase the dosage (amount) of narcotics on my own. If I do, I am aware I may be tapered off the narcotics and possibly discharged from Pain Management.

5. I understand that Dr. Courtney uses the prescription monitoring program and can access information regarding my prescriptions at any time.

6. I will keep my scheduled appointments with Dr. Courtney; I will give notice of cancellation 48 hours in advance (leave message if calling on weekends). I will be charged a fee of $65.00 for no-show or same day cancellations.

7. I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol as indicated by Dr. Courtney. I will bring my prescribed medications to every office visit and prescription renewal. Three (3) Business

days are required for any renewals. Business hours are Monday-Thursday 9-12 & 1-6:30 pm. Please check our notices, in our office, for any vacation, holiday closures for prevention of delays in your prescriptions.

8. I understand that Dr. Courtney will work with me to find the most appropriate treatment for chronic pain. I understand that the goals of treatment are not to eliminate pain, but to control my pain to improve my ability to function/or work. Chronic Opioid therapy is only ONE part of my overall pain management plan. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in all aspects of the program to maximize functioning and improve coping with my condition. If treatment for my condition(s) is available, I agree I will not refuse the treatment. If I do refuse treatment, Opioids may be titrated and discontinued. I have the right to refuse any procedure, but that does NOT mean that Dr. Courtney must continue to prescribe narcotics of any nature to me.

My treatment plan may change based on the outcome of therapy. If pain medications are ineffective such medications will be discontinued.

My treatment plan includes:

Medications _____
Physical therapy/exercise _____
Relaxation techniques _____
Psychological counseling _____

I understand that Dr. Courtney believes in the following "Pain Patients Bill of Rights." By signing below, I indicate that I understand AND agree to ALL the terms of the above agreement.

[ ] I need a copy or [ ] Do not need a copy, but it is in my chart.

Patient Signature _____

Reviewed by _____ Dated: ____/____/_____

SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN—REVISED (SOAPP®-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

Please include any additional information you wish about the above answers.

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Patient Name: _____ DOB: _____ Date: _____

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

During the past week, I have found that:	**Disagree <----------> Agree**						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
					Total Score:		

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

The Fatigue Severity Scale key

A total score of less than 36 suggests that you may not be suffering from fatigue.
A total score of 36 or more suggests that you may need further evaluation by a physician.

Your next steps

This scale should not be used to make your own diagnosis.
If your score is 36 or more, please share this information with your physician. Be sure to describe all your symptoms as clearly as possible to aid in your diagnosis and treatment.

Fatigue Severity Scale © Lauren B. Krupp. Reproduced with permission from the author.
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Patient Name: _____ DOB: _____ Date: _____

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing
It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0-3)**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place—for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
	Total Score:			

Scoring your results
Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key
A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.
A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps
This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.
If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.
It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Epworth Sleepiness Scale © MW Johns. Reproduced with permission from the author.

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Date: _____

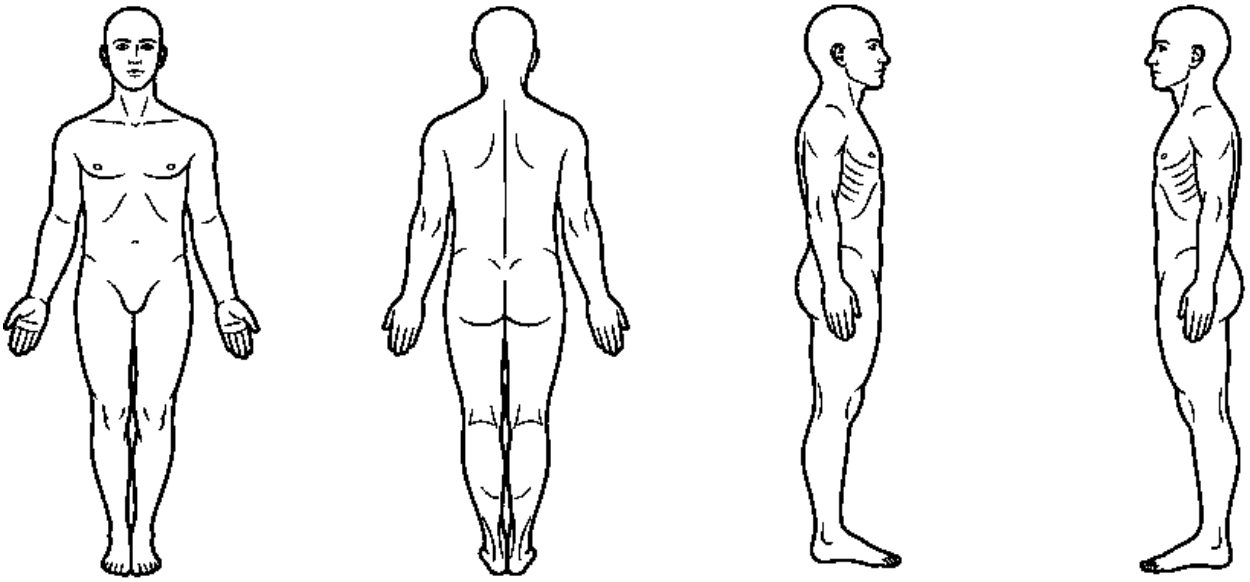
Name: _____ _____ _____
Last First Middle Initial

Age: _____ Referred by: _____

1. Where is your pain located? (Check areas.)

[ ] 1. Low Back
[ ] 2. Mid Back
[ ] 3. Upper Back
[ ] 4. Neck
[ ] 5. Chest
[ ] 6. Abdomen
[ ] 7. Groin
[ ] 8. Left Buttock
[ ] 10. Left Thigh
[ ] 11. Right Thigh
[ ] 12. Left Calf
[ ] 13. Right Calf
[ ] 14. Left Ankle or Foot
[ ] 15. Right Ankle or Foot
[ ] 16. Left Shoulder
[ ] 17. Right Shoulder
[ ] 19. Right Arm
[ ] 20. Left Hand or Wrist
[ ] 21. Right Hand or Wrist
[ ] 22. Head
[ ] 23. Face
[ ] 24. Other (List)
_____
_____

2. Please indicate on this diagram where your pain occurs by shading the painful area(s).



3. Use the following rating scales to indicate how severe your pain is at its worst, at its least severe and as it usually is. (Circle the appropriate number.)

Your pain at its worst:

NO PAIN 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 UNBEARABLE PAIN

Your pain at its least severe:

NO PAIN 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 UNBEARABLE PAIN

Your pain as it usually is:

NO PAIN 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 UNBEARABLE PAIN

Your pain at the present time:

NO PAIN 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 UNBEARABLE PAIN

4. Would you describe your pain as:

Burning? 1 [ ] Yes 2 [ ] No Throbbing? 1 [ ] Yes 2 [ ] No
Sharp? 1 [ ] Yes 2 [ ] No Aching? 1 [ ] Yes 2 [ ] No
Shooting? 1 [ ] Yes 2 [ ] No

Other (Describe) _____

5. Does your pain travel anywhere?

1 [ ] Yes 2 [ ] No

If yes, where? _____

6. Which statement best describes your pain?

1. [ ] Always present, always the same intensity
2. [ ] Always present, intensity varies
3. [ ] Usually present, but have short periods without pain
4. [ ] Often present, but have pain free periods lasting for one to several hours
5. [ ] Often present, but am pain free for most of the day
6. [ ] Occasionally present - have pain once to several times per day, lasting a few minutes to an hour
7. [ ] Occasionally present for brief periods, a few seconds to a few minutes
8. [ ] Rarely present - have pain every few days or weeks

7. What time of day is your pain worse?

1. [ ] Morning or arising
2. [ ] Later in the morning
3. [ ] Afternoon
4. [ ] Evening
5. [ ] Bedtime
6. [ ] Night (during usual sleeping hours)
7. [ ] Pain is always the same
8. [ ] Pain varies, but is not worse at any time

8. Do you have:

Numbness?	1 [ ] Yes	2 [ ] No
Tingling, pins and needles?	1 [ ] Yes	2 [ ] No
Weakness?	1 [ ] Yes	2 [ ] No
Coldness?	1 [ ] Yes	2 [ ] No
Increased sweating?	1 [ ] Yes	2 [ ] No
Muscle spasm, tightness?	1 [ ] Yes	2 [ ] No
Skin discoloration?	1 [ ] Yes	2 [ ] No
Bowel or bladder problems	1 [ ] Yes	2 [ ] No

9. Do any of the following make your pain feel worse?

Coughing, sneezing	1 [ ] Yes	2 [ ] No
Sitting	1 [ ] Yes	2 [ ] No
Standing	1 [ ] Yes	2 [ ] No
Lying down	1 [ ] Yes	2 [ ] No
Walking	1 [ ] Yes	2 [ ] No
Physical Activity	1 [ ] Yes	2 [ ] No
Sexual Activity	1 [ ] Yes	2 [ ] No

Other (Describe) _____

10. Do any of the following make your pain feel better?

Relaxation	1 [ ] Yes	2 [ ] No
Sitting	1 [ ] Yes	2 [ ] No
Standing	1 [ ] Yes	2 [ ] No
Lying down	1 [ ] Yes	2 [ ] No
Alcoholic Drinks	1 [ ] Yes	2 [ ] No
Sexual Activity	1 [ ] Yes	2 [ ] No
Heat	1 [ ] Yes	2 [ ] No
Medicines	1 [ ] Yes	2 [ ] No
Walking	1 [ ] Yes	2 [ ] No

Other (Describe) _____

11. Does pain interrupt your sleep? (Check One)

1. [ ] Not at all
2. [ ] Once per night
3. [ ] Twice per night
4. [ ] Three times per night
5. [ ] More than three times per night

12. When did you first notice your pain?

Month _____ Day _____ Year _____

13. Under what circumstances did pain begin? (Check One)

1. [ ] Accident at work
2. [ ] Accident at home
3. [ ] At work, but not an accident
4. [ ] Pain just began, no reason
5. [ ] Motor vehicle accident
6. [ ] Following surgery
7. [ ] Following illness
8. [ ] Other (Describe) _____

14. If pain began at work, please list:

Place of employment when pain began: _____

Date of injury: Month _____ Day _____ Year _____

How long had you been employed there? _____ Years _____ Months

Type of work: _____

15. If you were injured at work, describe how:

1. [ ] Fall
2. [ ] Lifting object
3. [ ] Pushing
4. [ ] Struck by falling object
5. [ ] Struck by object
6. [ ] Injured from repetitive activity
7. [ ] Other (Describe) _____
8. [ ] Not injured at work

16. Injury resulted from motor vehicle accident, were you:

1. [ ] Driving automobile/truck
2. [ ] Automobile/truck passenger
3. [ ] Driving Motorcycle
4. [ ] Motorcycle passenger
5. [ ] Pedestrian
6. [ ] Describe details: _____

17. When did you first see a doctor for the pain you now have?

Month _____ Day _____ Year _____

18. Have you been hospitalized for your pain?

1. [ ] Yes 2. [ ] No

If yes, please list:

Hospital	Date Admitted
_____	_____
_____	_____
_____	_____

19. Approximately how many physician visits have you had for your pain in the last year?

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] more than 5

20. How many visits for pain to other health care professionals (Physical Therapist, Occupational Therapist, Chiropractor, Acupuncturist, etc.)?

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] more than 5

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PERMISSION FOR TREATMENT

I, the undersigned hereby voluntarily consent to pain management care and/or pain management by Michael D. Courtney, M.D., deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me because of treatment or examination in the office.

Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Metabolic Health and Pain Management to furnish information to insurance carriers concerning my medical condition, illness, and treatment to determine the benefits for the related services. I hereby authorize (assign) my insurance carrier to pay directly to Metabolic Health and Pain Management for medical, diagnostic, procedural benefits payable for the services rendered. I understand that any unpaid balances not covered by this policy will be payable by myself. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collections agency and for any returned checks.

I understand Medicare and other carriers may not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to Metabolic Health and Pain Management.

I certify that the information I have given is true and correct to the best of my knowledge. I will notify Metabolic Health and Pain Management of any changes in my status or any changes in the information.

Signature: _____ Date: _____

DESIGNATED RELATIVE

I have designated _____ (relationship) _____
for release of my health information / medical status if needed in the future.

PRIVACY NOTICE

I have received a copy of this physician's office privacy notice as it relates to my personal health information.

Signature: _____ Date: _____

Patient Name (print) _____

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Prescription Renewal Policy

Our policy for renewal of prescriptions requires the patient to provide #3 (three) business days for prescriptions to be written and obtained from Dr. M. Courtney. Weekends and holidays are excluded from the #3 (three) days required. The first day is counted on the requested day of prescription. It is our policy to charge any patient that does not adhere to our policy a $20 (twenty dollar) fee for script requests not allowing #3 (three) business days. The charge is inclusive of the doctor's time for review of the chart and interruption of his office hours to accommodate the patient's request.

I _____ have read the above policy and agree to the $20 fee for non-compliance of the policy and procedures.

Thank you,

Dr. M. Courtney
Metabolic Health and Pain Management

Policies and Procedures

PAYMENT:

Payment is due at the time of service is rendered. We accept cash, credit cards, and debit cards only. Per our contracts with our insurance companies, we collect all co-pays prior to your doctor's visit. If you do not have the required amount, we will reschedule your appointment for another time. Our office will bill your primary insurance however if your secondary does not crossover with your primary insurance this may become your responsibility for payment. If you have any questions regarding your bill, please ask for our billing number or please check your invoice. Please note that verification for coverage is not a guarantee of coverage. You are responsible for all services rendered that are not covered by your insurance. We make every effort to confirm what your responsibility may be and inform you what we have been informed by your insurance.

MISSED APPOINTMENTS:

There is a $65.00 charge for missed appointments unless you advise us 48 hrs. in advance and all appointments are confirmed by you. We do not double book our appointments therefore your appointment time is scheduled for you, and we request your co-operation with this policy. If you are habitually late for your appointments, other scheduled appointments will be rendered services before you. You may wait to be seen or reschedule.

MEDICAL RECORDS:

All medical record requests require a written request from you with what you are requesting or need. All medical records require a 30-business day notice, please note our scheduled holidays and or vacations please allow for any sick days which are unforeseen. The cost for medical offices for continuity of care courtesy copy of last couple of office notes and or x-ray, labs are free to other facilities. For your own use, cost per page $1.00 for the first 25 pages and .50 cents thereafter. We will notify you when they are ready to be picked up. If we do not have your medical records readily available, they may be kept in storage if older than 3 years. Additional time will be needed for retrieval of those records.

DEDUCTIBLE:

If your deductible has not been met you will need to pay for our services up front. The percentage owed is based upon our standard charges. We try to inform you of your responsibility prior to your appointment, but it is not always possible if you know your policy. Please call us and ask for an amount as well. If there is an overlap in payments, we will issue a refund upon closure of all claims and refunds are quarterly. You may opt to apply to future co-pays, procedures etc.

BILLING INVOICES:

If you receive a bill from us, it is because your insurance has not submitted payment to our office. We ask that you contact your insurance to help get your claim paid, otherwise the balance will become your responsibility to pay.

COLLECTIONS:

A $5.00 fee will be charged for any invoice not paid in full within 30 days. Bills not paid after 3 attempts will be sent to a collection agency.

If you do not agree with our policies and procedures, please let us know so we can remove you from our schedule as soon as possible.

SIGN: _____ DATE: _____

Your Copy

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available to only designated staff and only for designated reasons. Housekeeping, maintenance, and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for the service of computer operations.

TYPICAL USE AND DISCLOSURES OF MEDICAL INFORMATION
We collect medical information from you with-in our office, we restrict the disclosure of this information to doctors, nurses, technicians, insurance, and billing personnel. Outside our office, we restrict the disclosure to those people, entities, and agencies for whom you authorize disclosure such as other health care providers (doctors, nurses, extended care facilities, insurance companies, billing agencies, hospitals, and surgery sites), or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (dental, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement request (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, and funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB approved or privacy board approved.
- Emergencies or to avert serious threat to health or safety
- Specialized government function (military, inmates)
- Workers compensation

We may contact you for appointment reminders, and we may provide you with information about health related or product benefits and services.

Each patient will be given a copy of The Privacy Notice if requested and an opportunity to review and understand it.

PATIENT PRIVACY RIGHTS AND HIPAA
YOU HAVE THE RIGHT TO:

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives your rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you have to put your request in writing and pay for the cost of copying and mailing, an invoice will be sent to you prior to mailing your records. In most cases, your copies must be given to you within 30 business days if readily available or 60 if it is not available on site. To amend any medical information you feel is not accurate in your chart. You may do this with a written request directed to our office. We must respond to your request with in a 60 day time frame.

Your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got new health insurance, but you can ask for another copy anytime.

You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider or pharmacy does not need to get paid by your insurance company.

OUR RESPONSIBILITIES UNDER HIPAA

We are required by law to maintain the privacy of your personal health information and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice if this notice has been changed and the effective date of the change. If you have any concerns about our privacy policy please notify us in writing.

EFFECTIVE 4/1/2003
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