ADVANCED
CARDIOVASCULAR
SPECIALISTS

Thomas A. Lombardo, MD
T. Randolph Lombardo, MD
Jorge A. Hernandez, MD
Alfred B. Brady, MD
Mark Fasulo, MD
Allen D. McGrew, DO, FACC
Sheila DeVaugh, APRN, BC
Greg Gilbreath, APRN, BC
Amanda J. Reneau, APRN, BC
Tracy Foster, APRN, BC

We are pleased you have chosen Advanced Cardiovascular Specialists, LLP (ACS) for your cardiovascular evaluation. In order to facilitate the new patient process, we are sending the attached forms for your completion. ***PLEASE COMPLETE THE FORMS IN DETAIL AND RETURN THEM TO THIS OFFICE PRIOR TO YOUR SCHEDULED APPOINTMENT ON _____, ***MAIL or FAX BACK****

You can fax the completed forms to 409-892-6792 or mail them to 755 N. 11th Street, Ste. P2200, Beaumont, TX 77702.

If you are taking any medication, **PLEASE BRING ALL OF YOUR MEDICINES WITH YOU** at the time of your visit!

We must have "**ALL**" paperwork back @ least 72 hrs prior to your appointment, Thanks.

*** PLEASE use BLACK ink ONLY to fill out the following pages!!

Thank you for giving us the opportunity to serve you.

755 N. 11th Street, Ste. P2200 Beaumont, Texas 77702 (409) 892-1192 Phone (409) 892-6792 Fax	2014 S. Wheeler Street, Ste. 200 Jasper, Texas 75951 (409) 383-1780 Phone (409) 381-8611 Fax	Tyler County Hospital Office 1100 Westbluff Woodville, TX 75979 (409) 892-1192 Phone (409) 892-6792 Fax

ADVANCED CARDIOVASCULAR SPECIALISTS

Thomas A. Lombardo, MD
T. Randolph Lombardo, MD
Jorge A. Hernandez, MD
Timothy K. Colgan, MD
Alfred B. Brady, MD
Alfred B. Brady, MD
Mark Fasulo, MD
Allen D. McGrew, DO, FACC
Sheila DeVaugh, APRN
Greg Gilbreath, APRN
Amanda J. Reneau, APRN
Tracy K Foster, APRN

CARDIOVASCULAR HISTORY

NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: MALE / FEMALE

Have you ever seen a Cardiologist before? Yes / No

If Yes, what was the Cardiologist's name and address? _____

CHIEF COMPLAINT: List the major symptom/problem that brought you to our office? Date of onset?

_____

Pharmacy Name: _____ Address _____ Phone# _____

CURRENT MEDICATIONS

(Please list ALL medicines currently taken including: aspirin, vitamins, over-the-counter, herbal, etc.)

	Name of Drug	Strength	Instructions	Prescribing physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

Do you have any known **DRUG ALLERGIES**? Yes / No
If yes - **please list drug name and the type of reaction is causes**: _____

SOCIAL HISTORY

1. Do you smoke? Yes / No / Never

If yes --- Packs per day _____ Number of years _____

Discontinued smoking? Yes / No How long ago? _____

2. Alcohol intake? Never / Occasionally / Socially How often? Daily / Weekly / Monthly

3. Diet: No Particular diet _____ Low Fat/Cholesterol _____ Diabetic _____ Other_____

4. Lifestyle: Single___ Married___ Widowed___ Divorced___ Other_____

5. Exercise: (walking, running, weights, working out in gym, etc.) _____

6. Education: High school education _____ College _____ Degree_____

7. Occupation:_____

FAMILY HISTORY

Please list family medical history (Age, Living/Deceased) of mother, father, brothers, sisters, etc.

Relationship	Sex	Age	Type of Problem	Age at Death
Mother				
Father				
Brothers / Sisters	M F			
	M F			
	M F			
Children	M F			
	M F			
	M F			

PAST MEDICAL HISTORY

{Please list any problems you may have had in the past}

HEENT: (Head, eyes, ears, nose & throat) _____
RESPIRATORY: (Chronic Lung disease, pneumonia, etc.) _____
HEART: _____
Stroke _____ Heart murmur _____ Thrombophlebitis _____ Congestive Heart Failure____
BONE & JOINT: _____
SKIN: _____
NEUROLOGICAL: _____
PSYCHIATRY: _____
ENDOCRINE: _____
VASCULAR: _____
GASTROINTESTINAL: _____
GENITOURINARY: _____
HEMATOLOGY: (Anemia, blood disorders, etc.) _____

Have you ever been diagnosed as having **HIGH CHOLESTEROL?** Yes / No
Have you ever been diagnosed as having **DIABETES?** Yes / No
Have you ever been diagnosed as having **HYPERTENSION?** Yes / No
Have you ever been diagnosed as having **RHEUMATIC FEVER?** Yes / No

PAST SURGICAL HISTORY

Please list ALL PAST SURGERIES: (Including DATE, HOSPITAL & SURGEON who performed surgery, including ANY PRIOR HEART SURGERY)

Type of Surgery	Hospital/Doctor	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have an Advance Directive Yes / No **If so please provide a copy**.

Do you have a Medical Power of Attorney Yes / No Name:_____

_____ Thomas A. Lombardo, M.D.
_____ T. Randolph Lombardo, M.D.
_____ Jorge A. Hernandez, M.D.
_____ Alfred B. Brady, M.D.
_____ Mark Fasulo, M.D.
_____ Allen D. McGrew, DO, FACC

PATIENT INFORMATION SHEET

_____ Sheila DeVaugh, APRN, BC
_____ Greg Gilbreath, APRN, BC
_____ Amanda Reneau, APRN, BC
_____ Tracy Foster, APRN, BC

Please fill out all information completely or this form will be returned to you.

Patient

NAME:_____ DATE OF BIRTH:_____ GENDER: M F

ADDRESS:_____ MARITAL STATUS: __Single __Married __Divorced __Widowed

CITY:_____ ST:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

SOCIAL SECURITY #:_____ DRIVERS LICENSE #:_____

FAMILY DOCTOR:_____ EMAIL :_____

Employer

RETIRED: _____ YES _____ NO

NAME:_____ WORK PHONE: _____

ADDRESS:_____

Spouse

NAME:_____ DOB:_____

HOME PHONE:_____ WORK PHONE:_____

SOCIAL SECURITY #: _____ EMPLOYER:_____

Emergency Contact – *Someone other than spouse*

NAME:_____ HOME PHONE:_____

ADDRESS:_____ RELATIONSHIP:_____

CITY:_____ ST:_____ ZIP:_____

Insurance - *A copy of your card must be on file*

PRIMARY CARRIER:_____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

PHONE:_____

POLICY HOLDER:_____ DOB:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER NAME:_____

MEMBER#:_____ GRP#_____

SECONDARY CARRIER:_____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

PHONE:_____

POLICY HOLDER:_____ DOB:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER NAME:_____

MEMBER#:_____ GRP#_____

ASSIGNMENT OF BENEFITS/CONSENT FOR TREATMENT

Name:_____ **DOB:**_____

I HEREBY AGREE TO PAY IN FULL FOR MEDICAL SERVICES BY ADVANCED CARDIOVASCULAR SPECIALISTS (ACS) AND/OR ITS STAFF, UNLESS OTHERWISE CONTRACTUALLY OR STATUTORILY PROHIBITED. UNLESS SPECIFICALLY PROHIBITED, I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURER, EMPLOYER, OR OTHER THIRD PARTY. I ALSO AGREE THAT ANY PAYMENT DUE FROM ME WILL BE MADE AT THE TIME SERVICES ARE RENDERED OR PROMPTLY UPON BILLING. I ACKNOWLEDGE THAT I/MY CHILD NEED MEDICAL SERVICES BECAUSE OF MY/ HIS/HER CONDITION. THEREFORE, I HEREBY DO VOLUNTARILY CONSENT TO MEDICAL TREATMENT AND/OR DIAGNOSTIC TESTING, AND OTHER MEDICAL SERVICES, UNDER THE GENERAL AND SPECIFIC INSTRUCTIONS OF THE PHYSICIANS OF ACS. THEIR ASSISTANT(S) OR THEIR DESIGNEE(S) AS IS NECESSARY IN HIS/HER JUDGEMENT. I ALSO ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OR OUTCOME OF TREATMENTS, EXAMINATIONS, OR TESTING BY THE PHYSICIANS OF ACS, THEIR ASSISTANT(S) OR THEIR DESIGNEE(S).

I AUTHORIZE AND REQUEST PAYMENT(S) OF MEDICAL BENEFITS DIRECTLY TO ACS OR THEIR DESIGNEE(S). I FURTHER AUTHORIZE AND DIRECT ACS, THEIR ASSISTANTS AND DESIGNEES TO RELEASE TO MY INSURANCE COMPANY(IES) ANY AND ALL MEDICAL INFORMATION (INCLUDING THAT OF A CONFIDENTIAL NATURE NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ADDITIONALLY AUTHORIZE ACS TO ORDER STAFF TO RELEASE COPIES OF MY/MY CHILD'S MEDICAL RECORDS (INCLUDING TESTING RESULTS, AND MEDICAL SERVICES OF A CONFIDENTIAL NATURE TO OTHER PHYSICIAN(S) GOVERNMENTAL AGENCIES, INSURANCE COMPANIES, ETC. AS I MAY DIRECT EITHER VERBALLY OR IN WRITING.

I AUTHORIZE: *ADVANCED CARDIOVASCULAR SPECIALISTS* TO RECEIVE INFORMATION IN CONNECTION WITH ANY ILLNESS/INJURY WHICH I HAVE SUFFERED OR ANY TREATMENT RENDERED TO ME.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

RELATIONSHIP TO PATIENT (IF LEGAL GUARDIAN) WITNESS

NURSE PRACTITIONER CONSENT

THIS FACILITY HAS ON STAFF, NURSE PRACTITIONERS TO ASSIST IN THE DELIVERY OF CARDIOVASCULAR CARE. A NURSE PRACTITIONER IS NOT A DOCTOR. A NURSE PRACTITIONER IS A REGISTERED NURSE WHO HAS RECEIVED ADVANCED EDUCATION AND TRAINING IN THE PROVISION OF HEALTH CARE. A NURSE PRACTITIONER CAN DIAGNOSE, TREAT, AND MONITOR COMMON ACUTE AND CHRONIC DISEASES AS WELL AS PROVIDE HEALTH MAINTENANCE CARE.

I HAVE READ THE ABOVE, AND HEREBY CONSENT TO THE SERVICES OF A NURSE PRACTITIONER FOR MY HEALTH CARE NEEDS. I UNDERSTAND THAT AT ANY TIME I CAN REFUSE TO SEE THE NURSE PRACTITIONER AND REQUEST TO SEE A PHYSICIAN**.**

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

RELATIONSHIP TO PATIENT (IF LEGAL GUARDIAN) WITNESS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

BY SIGNING THIS AUTHORIZATION, I AUTHORIZE ADVANCED CARDIOVASCULAR SPECIALISTS, LLP (ACS) TO USE AND/OR DISCLOSE CERTAIN PROTECTED HEALTH INFORMATION (PHI) ABOUT MYSELF. THIS AUTHORIZATION PERMITS ACS TO USE AND/OR DISCLOSE THE FOLLOWING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ABOUT ME. THE INFORMATION WILL BE USED OR DISCLOSED FOR THE FOLLOWING PURPOSE: **MEDICAL TREATMENT, INSURANCE INFORMATION, OR ANY ISSUE RELATED TO MY HEALTH CARE.** IF REQUESTED BY THE PATIENT, PURPOSE MAY BE LISTED AS "AT THE REQUEST OF THE INDIVIDUAL." THE PURPOSE (S) IS/ARE PROVIDED SO THAT I CAN MAKE AN INFORMED DECISION WHETHER TO ALLOW RELEASE OF THE INFORMATION. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM SIGNATURE DATE BELOW. THE PRACTICE WILL NOT RECEIVE PAYMENT OR OTHER REMUNERATION FROM A THIRD PARTY IN EXCHANGE FOR USING OR DISCLOSING THE PHI. I DO NOT HAVE TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE TREATMENT FROM ACS. IN FACT, I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION. WHEN MY INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPAA PRIVACY RULE. I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ACTED IN RELIANCE UPON THIS AUTHORIZATION. MY WRITTEN REVOCATION MUST BE SUBMITTED TO THE PRIVACY OFFICIAL AT: 755 N. 11TH ST., SUITE P2200, BEAUMONT, TX 77702

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

RELATIONSHIP TO PATIENT (IF LEGAL GUARDIAN) WITNESS

Advanced
Cardiovascular
Specialists

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information, then sign and date form at bottom.

Name of Practice: Advanced Cardiovascular Specialists

Patient Name: _____

Social Security Number: _____-_____-_____ **DOB:** ____/_____/_____

Purpose of request (who will be authorized to receive information):

I authorize the practice to disclose or provide protected health information, about me, to:

Entity/Person receiving information: Relationship to you:

_____

_____

_____

_____

Description of information to be disclosed: I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

_____lab results _____diagnostic test results _____billing/collections information

__√__any and all information in my health record including but not limited to the above mentioned as well as diagnoses, treatment plans and prognosis.

Purpose of disclosure (please list the purpose of the disclosure or check patient request):

_____

☐ At the request of the individual

Expirations or termination of authorization: This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization.

Please list an earlier expiration if less than one year: _____

Non-conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization at any time by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to the attention of Privacy Manager at:

Advanced Cardiovascular Specialists
755 N. 11th Street, P2200
Beaumont, TX 77702

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

Patient or Personal Representative Signature **Date**

Advanced
Cardiovascular
Specialists

Provider Request for Treatment, Payment, or Healthcare Operations Disclosure from Another Covered Entity

Purpose of authorization: A disclosure of protected health information (regarding the patient listed below) is requested for the purpose of _√__ treatment, ___ payment, ___ healthcare operations.

Description of information to be disclosed: I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

_____lab results _____diagnostic test results _____billing/collections information
__√__any and all information in the health record including but not limited to the above mentioned as well as diagnoses, treatment plans and prognosis.

Entity Requesting Information:
The patient information is being requested by:

Practice: **Advanced Cardiovascular Specialists**

Address: **755 N. 11th Street, P2200**

City, State, Zip: **Beaumont, TX 77702**

Phone: **(409) 892-1192**

Fax: **(409) 892-6792**

Entity Providing Information:

Practice: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Patient Information - The requested information is for the following patient:

_____ _____ _____
Patient Name Date of Birth Social Security Number

_____
Address City State Zip Code

Expirations or termination of authorization: This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization.

Non-conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization at any time by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to the attention of Privacy Manager at:

Advanced Cardiovascular Specialists
755 N. 11th Street, P2200
Beaumont, TX 77702

Re-disclosure: The providing entity has no control over the covered entity requesting the information. Therefore, the protected health information disclosed under this authorization will no longer be the responsibility of the entity providing the protected health information.

_____ _____
Patient or Personal Representative Signature **Date**

_____ _____
Requesting Provider's Signature **Date**

ADVANCED
CARDIOVASCULAR
SPECIALISTS

RECEIPT OF
NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of

ADVANCED CARDIOVASCULAR SPECIALISTS, L.L.P. 's

Notice of Privacy Practices.

_____

Signature of Patient Date

DOB: _____

Advanced
Cardiovascular
Specialists

Date:_____

Name:_____

DOB:_____

Peripheral Arterial Disease (PAD) Questionnaire

Answers to the following questions will help determine if you are at risk for PAD and if a vascular examination can help better assess your vascular health status. Please place a check mark in the column indicating Yes or No to the questions.

Questions	Yes	No
Do you have a history of: Heart Disease, High Blood pressure, Diabetes, Chronic Kidney Disease, TIA or Stroke (Circle all that apply)		
Do you currently or have you ever smoked?		
Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm) and or stent placement?		
Do you experience any pain/heaviness/cramping in your legs or feet while at rest?		
Do your feet get pale, discolored or bluish?		
Do you experience any pain in your legs or feet while at rest?		
Do you have sores or wounds on your toes, feet or legs that heal slowly or not at all?		
Is one of your legs of feet colder than the other?		
Do you have thick, yellow toenails that aren't growing?		
Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during waking/exercise?		
If YES to the question above, does the pain go away when you stop walking/exercising?		

Advanced Cardiovascular Specialists

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice, please contact our Privacy Manager at (409) 892-1192

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

- **You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices -** We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

- **You have the right to authorize other use and disclosure -** This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

- **You have the right to request an alternative means of confidential communication -** This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

- **You have the right to inspect and obtain a copy your PHI* -** This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

- **You have the right to request a restriction of your PHI* -** This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

- **You have the right to request an amendment to your protected health information* -** This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

- **You have the right to request a disclosure accountability* -** You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

- **You have the right to receive a privacy breach notice -** You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

- **Treatment -** We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

- **Payment -** Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

- **Healthcare Operations -** We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

- **Special Notices -** We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

  We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.
- **Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

- **To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

- **Other Permitted and Required Uses and Disclosures -** We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

Cassidy Bordeman (409) 892-1192