

## Welcome to Metro Family Physicians,

Thank you for choosing us to provide for your medical needs and trusting us with your care. We are a private Family Medicine group practice dedicated to serving our patients with the highest quality care in a professional and compassionate manner. We treat patients from newborns to the elderly and provide state of the art care for acute illness, chronic medical problems, wellness and anti-aging medicine, as well as minor outpatient surgical procedures. Kindly take a few moments to read and complete the attached paperwork in order for us to set up your electronic medical record, protect your privacy, and acquaint you with our office policies.

We are here to assist you to the best of our ability and make your experience with us as pleasant as possible. Our professional medical staff is comprised of three Board Certified Physicians, and three Family Nurse Practitioners. While we will make every effort to schedule appointments with the provider that you prefer, please be aware that if you need an appointment on short notice you may have to be scheduled with a different provider that has openings on that date.

If you are not already registered online with us, please take a moment to do so after your appointment today at [www.metrofamilyphysicians.com](http://www.metrofamilyphysicians.com) . The website will allow you to book online appointments and refill your routine prescriptions (these are prescriptions that you take repetitively that are not narcotics). We hope to give you access to your lab or test results eventually as we continue to develop our website.

We also feature a full range of anti-aging medical services. These include services such as laser photofacials, skin tightening, hair removal, wrinkle reduction, and medically supervised weight reduction/management, as well as post pregnancy body reshaping. We offer injectables that include Botox, Juavaderm and Radiesse to help keep the appearance of the face looking as it did...well a few years back. You will be pleasantly surprised at the affordability of our prices, and limited financing is available.

We thank you again for choosing Metro Family Physicians as your medical provider and look forward to a long and healthy relationship with you and your family.

Sincerely,

The Staff of Metro Family Physicians

**PATIENT INFORMATION:**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX M / F  
ADDRESS: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ MARRIED/SINGLE/DIVORCED/WIDOWED  
HOME PHONE: \_\_\_\_\_ CELL# \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_

**EMERGENCY** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_  
EMPLOYED \_\_\_\_\_ RETIRED \_\_\_\_\_ OTHER \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK # \_\_\_\_\_ EXT \_\_\_\_\_  
RESPONSIBLE PARTY: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ PHONE# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

INFORMATION OF THE PERSON WHO CARRIES THE POLICY: IF YOU CIRCLE ONE SELF: YES OR NO  
SUBSCRIBER NAME: \_\_\_\_\_ THEIR EMPLOYMENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ CELL: \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**SECONDARY INFORMATION:**

ARE YOU SIGNED UP FOR AN ONLINE ACCOUNT, SO YOU CAN MAKE APPOINTMENTS ONLINE? YES OR NO  
IF YES WOULD YOU LIKE TO BE ABLE TO CHECK FOR ALL LABS OR TEST RESULTS ONLINE? YES OR NO

THE FOLLOWING IS A LIST OF OUR EXCEPTIONALY PRICED AESTHETIC SERVICES. PLEASE CHECK OFF ANY SERVICES YOU WOULD BE INTERESTED IN LEARNING MORE ABOUT, AND HAVING A CONSULTATION TO RECEIVE A QUOTE FOR THE SERVICE OF INTEREST (**PLEASE BE ADVISED. THESE ARE COSMETIC PROCEDURES AND THEY ARE NOT COVERED BY YOUR HEALTH INSURANCE PLAN**)

LASER SKIN TIGHTENING (USED TO REJUVENATE AND TIGHTEN LOOSE SKIN FOR FACE OR BODY)  
FACE \_\_\_\_\_ ABDOMEN AREA \_\_\_\_\_ INNER THIGHS \_\_\_\_\_

LASER HAIR REMOVAL:  
AREA(S) THAT YOU WOULD LIKE TREATED \_\_\_\_\_

INJECTABLES (USED TO FILL IN WRINKLES AND OR TO PLUMP UP THE LIPS) WHICH WOULD YOU BE INTERESTED IN  
BOTOX \_\_\_\_\_ JUVADERM \_\_\_\_\_ RADIESSE \_\_\_\_\_

LASER WRINKLE REDUCTION (USED TO MINIMIZE EXSITING WRINKLES)  
FACE AREA \_\_\_\_\_ NECK \_\_\_\_\_ OR NECK AND FACE AREA \_\_\_\_\_

LASER SKIN REJUVENATION (USED TO CLEAR PIGMENTED AND VASCULAR LESIONS,( IE AGE SPOTS, VEINS ON FACE)  
FACE AREA \_\_\_\_\_ HANDS \_\_\_\_\_ HANDS AND FACE \_\_\_\_\_

VELASHAPE (EXCELLENT FOR RESHAPING OF POST BABY FIGURE)  
CELLULITE AND CIRCUMFERENCE REDUCTION \_\_\_\_\_

**OUR FINANCIAL POLICY**

**WE ARE DEDICATED TO PROVIDING THE BEST POSSIBLE CARE FOR YOU AND YOUR FAMILY, AND WE WANT YOU TO COMPLETELY UNDERSTAND OUR FINANCIAL POLICIES. PLEASE READ IN ITS ENTIRETY AND SIGN BELOW.**

**ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT VISA, MASTERCARD, CHECK AND CASH PAYMENTS.**

**AS A COURTESY METRO FAMILY PHYSICIANS WILL FILE A CLAIM TO YOUR INSURANCE PLAN. FOR US TO DO SO YOU MUST ASSIGN YOUR BENEFITS TO OUR PRACTICE. (PLEASE UNDERSTAND THAT YOU ARE THE ONLY ONE CONTRACTED WITH YOUR INSURANCE PLAN AND THE ONLY WAY TO FILE ON YOUR BEHALF IS FOR YOU TO SIGN OVER THE BENEFITS) THIS ALLOWS FOR PAYMENT TO BE PAID DIRECTLY TO METRO FAMILY PHYSICIANS. YOU ARE RESPONSIBLE FOR CO PAYMENTS AT THE TIME OF CHECKING IN FOR YOUR APPOINTMENT. IF YOU HAVE A DEDUCTIBLE OR CO INSURANCE % YOU WILL BE BILLED FOR THE BALANCE NOT COVERED BY YOUR PLAN, IT IS YOUR RESPONSIBILITY TO PAY THE BALANCE AT THE TIME YOU RECEIVE THE STATEMENT. IF FOR ANY REASON YOUR INSURANCE COMPANY DOES NOT PAY THE PRACTICE WITHIN A REASONABLE PERIOD OF TIME, WE WILL LOOK TO YOU FOR PAYMENT; THIS EXCLUDES HMO PATIENTS.**

**METRO FAMILY PHYSICIANS ARE CONTRACTED WITH MANY INSURANCE COMPANIES AND WE HAVE TO FOLLOW THE CONTRACTED GUIDLINES. WE ARE REQUIRED TO ASK FOR ALL CO PAYMENTS AT THE TIME THE SERVICE(S) IS RENDERED, IF FOR ANY REASON YOU DO NOT FOLLOW YOUR INSURANCE COMPANIES GUIDLINES AND COME TO METRO FAMILY PHYSICIANS NOT PREPARED WITH PAYMENT FOR YOUR CO PAYMENT, THERE WILL BE AN ASSESSED FEE OF \$25.00 LATE FEE ATTACHED FOR ANY MISSED CO PAYMENTS.**

**WE WILL BILL YOUR INSURANCE COMPANY FOR ALL PHYSICIAN SERVICES PROVIDED IN THE HOSPITAL AND OR THE OFFICE. YOU ARE RESPONSIBLE FOR ANY AND ALL BALANCES DUE.**

**PLEASE BE AWARE THAT NOT ALL INSURANCE PLANS COVER ALL SERVICES. IN THE EVENT YOUR INSURANCE PLAN DETERMINES A SERVICE IS NOT COVERED, YOU WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT. IT IS IMPOSSIBLE FOR US TO KNOW THE DETAILS OF EVERY INSURANCE PLAN; THEREFORE IT IS YOUR RESPONSIBILITY TO KNOW THE COVERAGE OF YOUR PLAN. IF FOR ANY REASON UPON FILING A CLAIM WITH YOUR INSURANCE PLAN, WE RECEIVE A NOTICE THAT YOUR INSURANCE INFORMATION PROVIDED TO US BY YOU WAS NOT CORRECT OR IF YOUR PLAN IS TERMINATED FOR ANY REASON, YOU WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT. PAYMENT IS DUE UPON RECEIPT OF A STATEMENT FROM OUR OFFICE.**

**IF YOU ARE INSURED BY A PLAN THAT WE ARE NOT CONTRACTED WITH, WE WILL PROVIDE YOU WITH A PREPARED CLAIM FOR YOU ON AN UNASSIGNED BASIC FORM FOR YOU TO FILE, PAYMENT WILL BE EXPECTED FROM YOU AT THE TIME OF SERVICE(S) RENDERED. YOUR INSURANCE COMPANY WILL DIRECTLY REINBURSE YOU FOR THE SERVICES PROVIDED UNDER THEIR CONTRACTED GUIDLINES WITH YOU.**

**THERE WILL BE AN ASSESSED FEE OF \$25.00 FOR ANY RETURNED CHECK AND THIS WILL BE ADDED TO THE AMOUNT OF THE ORIGINAL CHECK AND THIS NEEDS TO BE PAID BEFORE SCHEDULING ANY OTHER FUTURE APPOINTMENTS AND WE WILL NO LONGER ACCEPT YOUR CHECK, YOU MUST PAY BY CASH OR CREDIT CARD.**

**THERE WILL BE AN ASSESSED FEE OF \$50.00 FOR ANY APPOINTMENT CANCELLED WITHOUT A 24 HOUR NOTICE OR IF YOU ARE "A NO SHOW" FOR YOUR SCHEDULED APPOINTMENT.**

**I HAVE READ AND FULLY UNDERSTAND METRO FAMILY PHYSICIAN'S FINANCIAL POLICIES AND I AGREE TO ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE ADMENDED BY THE PRACTICE FROM TIME TO TIME.**

**PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**PRINT NAME: \_\_\_\_\_**

**Metro Family’s Office Policy Concerning Your Insurance Carrier.**

In order to meet needs and request of our patients, we have enrolled in numerous managed care insurance programs.

We are very pleased to be able to provide this service to you, but it is extremely difficult for us to keep track of all the individual requirements of each insurance plans. Each plan has different stipulations regarding how often services may be rendered and even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ, depending upon the type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide you with the care that is within your insurance contracted guidelines. It is your responsibility to know what those guidelines are and inform us before services are rendered, unfortunately if you do not know or do not inform us of special insurance requirements and we subsequently provide services that we feel you need for your care and the services are not covered, those charges become your responsibility and we will bill directly to you for those services..

We understand that sometimes a patient does not know what is covered and what is not covered under their plan and just as often Metro Family Physicians Medical Group does not and can not know the coverage of each patient’s insurance plan.

With your cooperation and help, you will receive all the benefits offered to you.

I have read and fully understand the office policy stated above and agree to accept the responsibility as described. I agree to accept this responsibility for the duration of my care at the office of Metro Family Physicians Medical Group.

Patient/ Guardian: Print name \_\_\_\_\_

Patient/ Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT CONSENTS**

1) **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address:

\_\_\_\_\_

Preferred phone # \_\_\_\_\_ Alternate phone# \_\_\_\_\_

I \_\_\_\_\_ give Metro Family Physicians Medical Group (MFPMG)

Permission to leave health information with my spouse/partner listed \_\_\_\_\_

Or leave a detailed message with lab/ test results on my answering service # \_\_\_\_\_.

I know that if I have any questions regarding the information left, I may call MFPMG during regular business hours. To make changes to this consent in the way I receive my health information, I understand that I will need to complete a new consent before any change will be made.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2) **PATIENT CONSENT TO BE TREATED**

I, \_\_\_\_\_, consent to being treated as a patient at

Metro Family Physicians Medical Group (MFPMG). I request the physician/nurse practitioners/physician assistants and their nursing staff to give me the examinations, treatments, diagnostic tests, injections and medications which they believe are advisable and necessary for me. I request the opportunity to ask my physician/nurse practitioner/physician assistant questions about my condition, benefits and possible risks of any proposed examinations or treatments.

If I need to be referred to a subspecialty physician, I hereby authorize Metro Family Physician Group (MFPMG) to make my medical information available to the appropriate consultant.

I also authorize Metro Family Medical Group (MFPMG) and my physician/nurse practitioner/physician assistant to submit any requested or necessary information to my insurance company (s) or organizations from which payment may be requested on my behalf.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 "HIPPA". I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED:

**CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN TREATMENT DIRECTLY AND INDIRECTLY.**

**OBTAIN PAYMENT FROM THIRD PARTY PAYERS.**

**CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.**

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE IT'S NOTICE OF PRIVACY PRACTICES AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE TO OBTAIN A CURRENT COPY OF NOTICE OF PRIVATE PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME: \_\_\_\_\_

RELATIONSHIP TO THE PATIENT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

OFFICIAL USE BELOW

**I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:**

**DATE: \_\_\_\_\_ INITIALS: \_\_\_\_\_ REASON: \_\_\_\_\_**

**THIS PATIENT CONFIDENTIALITY STATEMENT EXPLAINS YOUR RIGHTS, OR LEGAL DUTIES AND OUR PRIVACY PRACTICES. WE DISCLOSE THAT WE PROTECT THE CONFIDENTIALITY OF OUR PATIENT'S PERSONAL HEALTH AND PERSONAL FINANCIAL INFORMATION, INTERNAL POLICIES, AND PROCEDURES AS REQUIRED BY LAW.**

**PLEASE READ THIS NOTICE CAREFULLY. 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

#### **Our Pledge Regarding Your Health Information**

We are dedicated to maintaining the privacy of your health. We are required to provide you with this notice of the privacy practices that we maintain in our practice concerning your health information. The terms of this notice apply to all records of your health information that are created or retained by our practice. We reserve 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. We collect, use and disclose information provided by and about you for healthcare, payment and operations, or when we are otherwise permitted or required by law to do so.

#### **For Treatment**

We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. For example, we may ask you to have laboratory tests (such as blood tests), and we may use the results to help determine pre-operative wellness. We might use your PHI in order to write a prescription for you. Many of the people who work for our practice, including but not limited to, our doctor and nurses or MA's may use or disclose your PHI in order to treat you or to 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. In addition, we may disclose your PHI from time-to-time to another provider (e.g., a specialist or laboratory) who, at the request of your provider, becomes involved in your care.

#### **Payment**

Our practice may use and disclose your PHI in order to bill and collect payment for the services and products you may receive from us. We also may use and disclose your PHI to obtain payment from other third parties, such as a collection agency, and to bill you directly for services and supplies.

#### **Healthcare Operations**

Our practice may use and disclose your PHI to operate our business. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing, and for business activities. For example, your name may be called in the waiting room when it is time for your appointment. We may use or disclose your PHI to contact you to remind you of your appointment.

"Business Associates" perform various activities (e.g., answering service) for us. We will share your PHI with business associates whenever appropriate. A written contract with the business associate will outline the terms that will protect the privacy of your PHI.

#### **Communications from Our Office**

We might use or disclose your PHI to discuss with you information about treatment alternatives or other health-related services. We may also use and disclose your PHI for other marketing activities. For example; your name, address or e-mail may be used to send you a newsletter about services our practice offers. You may contact our Privacy Officer to request that these materials not be sent to you.

#### **OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT**

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply.

#### **Disclosures Required By Law**

We may use and disclose PHI as required by federal, state or local law. Any disclosure must comply with the law and is limited to the requirements of the law.

#### **Public Health Activities**

We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability;
- To report disease, injury, birth or death;
- To report child abuse or neglect;
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- To locate and notify persons of recalls of products they may be using;
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

#### **Health Oversight Activities**

We may disclose PHI to a health oversight agency for oversight activities including, for example, claims audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the health care system, and compliance with certain laws.

#### **Lawsuits and Other Legal Proceedings**

We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal processes when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

### Law Enforcement

Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency;
- To alert law enforcement of a death that we suspect was the result of criminal conduct;
- Required by law;
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a crime or suspected crime committed at the workplace; or
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

### 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 family member or friend who would be taking care of you after surgery, may be given aftercare instructions, or you may ask your friend or family member to pick up a prescription, which would give them access to your medical information. If this is not acceptable to you, please request in writing that your records are not to be released to anyone.

### Disclosures Required by HIPAA Privacy Rule

We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required to certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you as described in Section "Your Rights" of this notice.

### Emergencies

We may use or disclose your PHI in an emergency treatment situation.

### You're Rights

Under regulations that were in effect April 14, 2003, you have a right over your health information. Under these rules, you have the right to:

- **Confidential Communications.** Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address, if communications to your home address could endanger you.
- **You have the right to request a restriction of your PHI.** Send us a written request to see or to get a copy of information that we have about you, or to amend your personal information that you believe is incomplete or inaccurate. Request additional restrictions on uses or disclosures of your health information. **This facility is not required to agree to a restriction.** If our provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If our provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the provider. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Office Manager at the address above. Your request must describe in a clear and concise fashion:
  - The information you wish restricted;
  - Whether you are requesting to limit our practice's use, disclosure or both; and
  - To whom you want the limits to apply.
- **You have the right to inspect and copy your PHI.** This means you may inspect and obtain a copy of PHI about you that is contained in your medical record. A medical record contains medical and financial information and any other records that your provider uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record. You must submit your request in writing to Medical Records Dept 7910 Frost St. #410 San Diego, CA. 92123, 858-514-3700 in order to inspect and/or obtain a copy of your medical record. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
- **Right to Amend.** You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing to our Privacy officer. You must also give us a reason for your request. We may deny your request to certain cases, including if it is not in writing or if you do not give us a reason for the request.
- **Right to Receive an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years except for disclosures made:
  - For treatment, payment, and health care operations;
  - For use in or related to a facility directory;
  - To family members or friends involved in your care;
  - To you directly;
  - Pursuant to an authorization of you and your personal representative;
  - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); or
  - Before April 14, 2003
- **Right to a Paper Copy of this Notice.** You have a right to receive a paper copy of this notice at any time, even if you have previously agreed to receive this notice electronically. To obtain a paper copy of this notice, contact the Privacy Officer.

### Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with our office or with the federal government. You will not be penalized for filing a complaint.

### Contact Information

If you have any questions regarding this notice or our health information privacy policy, please contact the front office personnel or: Debra Penne, Privacy Officer – 7910 Frost St. #410 San Diego, CA 92123 858-514-3700