CAPITAL
INTERVENTIONAL
PAIN & SPINE CENTER

Phone (301) 841-6600

Fax (301) 841-6500

Web capitalpaincenter.com

WELCOME TO OUR OFFICE

Enclosed you will find forms to be completed in their entirety and given to us at the time of your visit. This will save you considerable amount of time on the day of the examination. Please bring the following items with you to the appointment:

Photo ID and Insurance Card(s)
These will be photocopied. Without these cards we will not be able to see you on your appointment date and you will be rescheduled.

List of Medications
Just a list, you do not need to bring in the actual medications.

Previous Tests (MRI, Xray, CT-Scan, Etc.)
If you have been tested previously and have the results of those examination, please bring them with you. They will be helpful in assessing your case.

Co-Payments
If your insurance requires a co-payment, they are expected at the time of your visit. Your co-pay is usually printed on the front of your insurance card.

If you have any questions, please feel free to call us at (301) 841-6600

Thank you, we look forward to seeing you soon.

Akshay Garg, MD

Owner & Medical Director

Capital Interventional Pain & Spine Center

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PATIENT DEMOGRAPHICS

FULL NAME: _____ SEX:_____ DOB ___/___/_____

_____

ADDRESS CITY STATE ZIP

_____

HOME PHONE CELL PHONE EMAIL

_____

EMERGENCY CONTACT PHONE RELATIONSHIP

RACE: _____ PRIMARY LANGUAGE:_____ MARITAL STATUS:_____

EMPLOYMENT STATUS

EMPLOYED: FT / PT / NO _____

EMPLOYER EMPLOYER PHONE #

IS YOUR CONDITION THE RESULT OF AN AUTO ACCIDENT? YES / NO

IS YOUR CONDITION THE RESULT OF AN INJURY WHILE AT WORK? YES / NO

IS YOUR CONDITION PART OF A WORKERS COMPENSATION CASE? YES / NO

IF THIS IS AN INJURY CASE, DO YOU HAVE AN ATTORNEY FOR THIS INJURY? YES / NO

_____

ATTORNEY ATTORNEY PHONE

By providing my email address or cell phone number, I hereby consent and state my preference to have my physician and other staff at Capital Interventional Pain & Spine Center, LLC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS may be insecure and could potentially be intercepted by a third-party.

_____ _____

Signature Date

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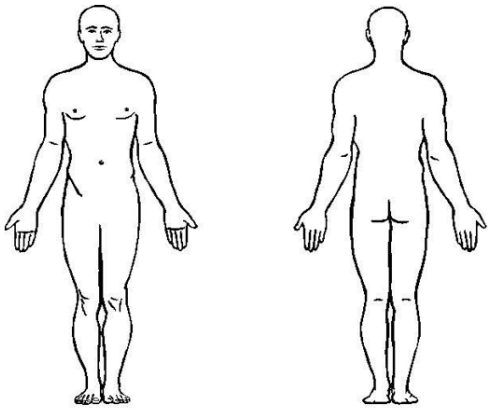
NEW PATIENT QUESTIONNAIRE

Referring Physician: _____
(first & last name)

Primary Care Physician: _____
(first & last name)

Where do you feel your pain? _____

Circle the locations you have pain:



When did your pain begin? _____

Was there an event that caused your pain?
_____

Describe your pain (circle all that apply):

Sharp	*Dull*	*Achy*
Burning	*Numbness*	*Tingling*
Electric	*Stabbing*	*Throbbing*

Timing of pain (circle all that apply):

Morning	*Afternoon*	*Night*

Activities limited by the pain (circle all that apply):

Bathing/Showering	*Dressing*	*Grooming*
Using the toilet	*Walking*	*Eating*
Getting in/out of bed, chair, car		

What makes your pain better? *(i.e. sitting, lying down, heat, cold, standing, etc)*
_____

What makes your pain worse? *(i.e. movement, walking, bending over, weather, etc)*
_____

How would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10
No Pain *Worst pain imaginable*

Other Symptoms or Concerns:
_____
_____

Previously Tried Pain Medications:
_____
_____
_____

PREVIOUSLY TRIED THERAPIES:

Physical Therapy: *YES / NO*
If yes where:_____
For how long?: _____

Chiropractic Care: *YES / NO*

Injections: *YES/ NO*

Surgery: *YES / NO*

Previous Imaging and Name(s) of Facility:
_____
_____

ALL Current Medications / Dose / How often taken

_____
_____
_____
_____
_____

Diabetes (high blood sugar): *YES / NO*

Bleeding Disorder: *YES / NO*

Cancer: Yes/No; Type: _____

Other Medical Conditions:

_____
_____
_____
_____

Medication Allergies and Reaction:

_____
_____

Are you on blood thinners? *YES / NO*
If yes, which one(s)?_____

Previous Hospitalizations/Surgeries and Dates:

_____
_____
_____

Family History

Circle any of the following that run in your family:
Similar pain *Arthritis*
Depression *Bleeding disorder*
Cancer

Social History

Do you use tobacco products? *YES / NO*

Do you drink alcohol? *YES / NO*

Do you use illicit drugs? *YES / NO*

Do you use/smoke Marijuana? *YES / NO*

Name of Pharmacy & Address

_____
_____

REVIEW OF SYSTEMS

If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you are not experiencing any of these symptoms, do not circle any items.

General / Constitutional: Fevers, chills, night sweats, weight gain, weight loss.
Other:_____

Allergy / Immunology: Congestion, hives, cough, itching, rash, recurrent serious infections, wheezing. Other:_____

Ophthalmologic: Blurry vision, change in vision, dry eye(s), loss of vision.
Other: _____

Ears, Nose, and Throat: Decreased sense of smell, difficulty swallowing, sinus pain, ringing in ears, sore throat. Other:_____

Endocrine: Cold intolerance, excessive sweating, excessive thirst, frequent urination, heat intolerance. Other:_____

Respiratory: Chest pain, cough, shortness of breath. Other: _____

Cardiovascular: Chest pain, cyanosis, chest pain with exertion.
Other:_____

Gastrointestinal: Abdominal pain, blood in stool, diarrhea, nausea, rectal bleeding, vomiting.
Other: _____

Hematology: Easy bleeding, bleeding problems, easy bruising.
Other:_____

Genitourinary: Blood in the urine, frequent urination, painful urination.
Other:_____

Peripheral Vascular: Absent pulses in feet, absent pulses in hands.
Other:_____

Psychiatric: Suicidal thoughts, auditory / visual hallucinations, delusions.
Other:_____

CERTIFICATION

I certify that the above information is accurate, complete, and true. I understand that this will become part of my medical record.

_____
Patient Signature (Patient, Guardian, or Representative)

_____
Printed Name

_____
Date

THE REVISED OSWESTRY PAIN DISABILITY QUESTIONNAIRE

Patient Name:_____ Date_____

Please read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities. Please answer each section by circling the one choice that applies to you. We realize that you may feel that more than one statement may relate to you, but please, just circle the one choice which most closely describes your problem right now.

SECTION 1- Pain Intensity A. The pain comes and goes and is very mild. B. The pain is mild and does not vary much. C. The pain comes and goes and is moderate. D. The pain is moderate and does not vary much. E. The pain comes and goes and it is severe F. The pain is severe and does not vary much.	SECTION 6- Standing A. I can stand as long as I want without pain B. I have some pain on standing but it does not increase with time C. I cannot stand for longer than one hour without increasing pain D. I cannot stand for longer than 1/2 hour without increasing pain E. I cannot stand for longer than 10 minutes without increasing pain F. I avoid standing because it increased pain straight away
SECTION 2- Personal Care A. I do not have to change my way of washing or dressing in order to avoid pain. B. I do not normally change my way of washing or dressing even though it causes some pain. C. Washing and dressing increases the pain but I managed not to change my way of doing it. D. Washing and dressing increases the pain and I find it necessary to change my way of doing it. E. Because of the pain I am unable to do some washing and dressing without help. F. Because of the pain I am unable to do any washing and dressing without help.	SECTION 7- Sleeping A. I get no pain in bed B. I get pain in bed but it does not prevent me from sleeping well C. Because of pain my normal night's sleep is reduced by less than 1/4 D. Because of pain my normal night's sleep is reduced by less than 1/2 E. Because of pain my normal night's sleep is reduced by less than 3/4 F. Pain prevents me from sleeping at all
SECTION 3- Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights but it causes extra pain. C. Pain prevents me from lifting heavy weights off the floor. D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. E. Pain Prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. F. I can only lift very light weights at the most.	SECTION 8- Social Life A. My social life is normal and gives me no pain B. My social life is normal but increases the degree of my pain C. Pain has no significant effect on my social life apart from limiting my more energetic interests e.g., dancing, etc. D. Pain has restricted my social life and I do not go out very often E. Pain has restricted my social life to home F. I have hardly any social life because of the pain
SECTION 4- Walking A. I have no pain walking B. I have some pain on walking but it does not increase with distance C. I cannot walk more than one mile without increasing pain D. I cannot walk more than 1/2 mile without increasing pain E. I cannot walk more than 1/4 mile without increasing pain F. I cannot walk at all without increasing pain	SECTION 9- Travel A. I get no pain while traveling B. I get some pain while traveling, but none of my usual forms of travel make it any worse C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel D. I get extra pain while traveling, which compels me to seek alternative forms of travel E. Pain restricts all forms of travel F. Pain prevents all forms of travel expect that done lying down
SECTION 5- Sitting A. I can sit in any chair as long as I like without pain B. I can sit only in my favorite chair as long as I like C. Pain prevents me from sitting more than 1 hour D. Pain prevents me from sitting more than 1/2 hour E. Pain prevents me from sitting more than 10 minutes F. I avoid sitting because it increases pain straight away	SECTION 10 – Changing Degree of Pain A. My pain is rapidly getting better. B. My pain fluctuates, but overall is definitely getting better. C. My pain seems to be getting better, but improvement is slow at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.

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Medical Treatment Consent Form

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

CONSENT FOR TREATMENT & EVALUATION

I voluntarily request that Capital Interventional Pain and Spine Center, LLC provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing, and treatment, which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If minimally invasive interventional treatment is recommended, I will be informed of the nature and purpose of the treatment with an explanation of benefits and risks prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

RELEASE OF INFORMATION

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices, which I have full access to view. I authorize Capital Interventional Pain and Spine Center, LLC physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written, or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____

Patient Signature (or Parent, if Patient is a minor) Date Printed Name

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You are financially responsible for the medical services you receive at the Capital Interventional Pain and Spine Center, LLC (hereafter referred to as "CIPSC"). Please carefully review this Financial Policy, initial each section, and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **Copayments, Deductibles, and Coinsurance.**
   Copayments, deductibles, and coinsurance for clinic visits are due at the time of service, in accordance with the carrier's plan. If you are unable to pay at the time of services, CIPSC reserves the right to reschedule your appointment until such time that you are able to make your payment. Deductibles and coinsurances are calculated as an estimate and may be adjusted after treatment based on any changes to services rendered or medications used.
2. **Procedure Prepayment**.
   CIPSC may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is an estimate of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.
3. **Self-Pay.**
   If you do not have health insurance, if your health insurance will not pay for services rendered, or if you notify us not to bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Payment is due in full at time of service.
4. **Missed Appointments, Late Arrivals, and Cancellation**.
   Missed appointments and cancellations within 24 hours will result in a $50.00 fee for each incident for a clinic visit, and a $100 fee for each incident for a procedure visit . The charges are your personal responsibility and will not be charged to your insurance carrier. If you arrive more than 10 minutes late for your appointment, you may be rescheduled to the next available time slot.

Initial:_____

INSURANCE PAYMENTS

1. **Financial Responsibility**. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment, in full, for all medical services provided. Any charges not paid by the carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.
2. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which a claim can be submitted on your behalf. If CIPSC is unable to process your claim within this period due to incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

Initial:_____

BENEFITS AND AUTHORIZATION

1. **Insurance Plan Participation**.
   CIPSC has specific network agreements with many insurance carriers, but not all. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.
2. **Referrals**.

Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by CIPSC, it is your responsibility to obtain this referral prior to your appointment. Without a referral, you will hold financial responsibility for the visit and subsequent services rendered. Although, your referring health care provider, and CIPSC, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, CIPSC is not required to agree with you. As a matter of course, CIPSC will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or by an employee of CIPSC.

3. **Prior Authorization and Non-Covered Services.**
   CIPSC may provide services that your insurance carrier's plan excludes or requires prior authorization. CIPSC, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that service provided to you are covered benefits and authorized by your insurance carrier.
4. **Out-of-Network Payments and Direct Insurer Payments.**
   You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly for services rendered, you are obligated to forward the payment to CIPSC immediately.

Initial:_____

ACCOUNT BALANCES AND PAYMENTS

1. **Reassignment of Balances**.
   If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 10 days of receiving an initial statement.
2. **Collection of Unpaid Accounts**.
   If you have an outstanding balance over 90 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection and a 35% penalty fee of your balance will be applied. This may result in adverse reporting to credit bureaus and additional legal action. CIPSC reserves the right to refuse treatment to patients with outstanding balances over 30 days old. You agree, in order for us to service our account or to collect any amounts you owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail. Methods of contact may include using pre-recorded voice messages or use of an automatic dialing device.
3. **Returned Checks.**
   You will be charged a service fee of $35.00 for all returned checks.
4. **Refunds.**
   Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Capital Interventional Pain and Spine Center, LLC, 3204 Tower Oaks Ste 440, Rockville, MD 20852
5. **Statements.**
   Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 10 days of receipt.

Initial:_____

ADDITIONAL FEES

1. **Medical Records Requests**.
   The Privacy Rule allows you to receive a copy of your personal medical and billing records. CIPSC requires individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. If you are unable to visit the office, CIPSC will make every effort to accommodate your request. A processing fee may apply.

Initial:_____

2. **Other Forms.**
   At the provider's discretion, the Practice will respond to requests for the completion of certain medical forms, provided the patient is in good standing with CIPSC. Other forms not listed may also be considered. A fee for medical form completion will be determined by CIPSC, and all requests require an office visit.

Initial:_____

3. **Notice of Privacy Practices & Statement of Patient's Rights**.
   A copy of the Notice of Privacy Practices and Statement of Patient's Rights is available upon request from the front desk and can be downloaded on our website: www.CapitalPainCenter.com. By initialing this section, I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and Statement of Patient's Rights.

Initial:_____

PRACTICE CODE OF CONDUCT

We are pleased to serve you and glad that you chose the Capital Interventional Pain and Spine Center as your new pain management provider. We will always strive to provide exceptional care for you.
Reasons that CIPSC may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone encounters. This also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures as this adversely limits our availability and care for other patients
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Failure to adhere to the Opioid / Pain Management Agreement
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments and participate in all treatments and diagnostic testing.

Initial:_____

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the Financial Policy and Consent of Capital Interventional Pain and Spine Center, LLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to CIPSC. I understand that I am financially responsible for all services I receive from CIPSC. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

_____

Patient Signature (or Parent, if Patient is a minor) Date Printed Name

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(By signing this form, you can allow our office to obtain your medical records from your other physicians.)

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initialing this form, I am specifically authorizing that release of this information.

Patient Name:_____

Date of Birth:_____ Phone Number:_____

By signing this form, I authorize the requested facility to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

Capital Interventional Pain & Spine Center
Fax: (301) 841-6500
Phone: (301)841-6600
www.capitalpaincenter.com
3204 Tower Oaks Blvd, Suite 440
Rockville, MD 20852

I do give permission for these records to be faxed to the above entity. Please forward:
____Office Visit Notes & Operative Reports
____Initial History and Physical
____MRI, CT, Xray, and other Imaging Reports
____Lab Reports
____Correspondence
____Insurance Information
Other (please specify):_____

Patient Signature: _____ Date:_____

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PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

Each patient has the right to:

- Exercise these rights without regard to sex or culture, economic, educational, or religious background or the source of payment for his or her care.
- Considerate, dignified and respectful care.
- Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see this patient.
- Receive a verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in Title 16 Health and Safety, 4400 Health Systems Protection.
- Request a copy of this document for yourself.
- Receive information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easy to understand terminology, and when appropriate this may include family members.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved and knowledge of the name of the person who will carry out the procedure or treatment.
- Participate actively in decisions regarding his/her medical care, to the extent permitted by law, including the right to refuse treatment. If adjudicated unable to make their own decisions, the patient will have someone with him or available by phone to make responsible healthcare decisions.
- The right to information regarding Advanced Directives.
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.
- A pain management plan.
- Be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.
- Confidential treatment of all communications and records pertaining to his/her care. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Reasonable responses to reasonable requests he/she may make for services.
- He or she may leave the Center even against the advice of his/her physicians.
- Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
- Be advised if physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in any such research projects.
- Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the facility

PATIENT RESPONSIBILITIES

The patient has a responsibility to:

- Provide accurate and complete information about matters relating to his/her health history, any medications taken, including over-the-counter products and dietary supplements, and any allergies and sensitivities, in order for the patient to receive effective medical treatment.
- To report whether he/she clearly comprehends a contemplated course of action and what is expected of them.
- Cooperate with all Center personnel and ask questions if directions and/or procedures are not clearly understood.
- Be considerate of other patients and Center personnel and to observe the smoking policy of the Center. A patient is also expected to be respectful of the property of other persons and the property of the Center.
- Help the physicians, nurses, and other health personnel in their efforts to care for the patient by following their instructions and medical orders both at the Center and, if applicable, outside the Center (i.e. at their home).
- Assume the financial responsibility of paying for all services rendered whether through third party payors (his/her insurance company) or being personally responsible for payment for any services which are not covered by his/her insurance policies.
- Not take any drugs which have not been prescribed by his/her attending physician and/or prescribed or administered by the Center staff and shall fully disclose any drugs and/or other substances which the patient may have ingested and which could affect the current course of treatment contemplated at the Center.
- Provide a driver on the day of a procedure, if directed to do so by physician, and a responsible person who will stay with you for 24 hours, if indicated.

AUDIO/VIDEO RECORDING PROHIBITED

Please be advised that, in order to better enable us to assure compliance with HIPAA Privacy and Security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited. We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this office policy. We appreciate your understanding and cooperation.

PATIENT'S RIGHTS FOR SUBMISSION AND INVESTIGATION OF GRIEVANCES

Grievances may be submitted in writing to the front office staff or via the messaging service on www.CapitalPainCenter.com
A letter or phone call will be completed addressing the problem to the patient and/or caregiver within 15 days of submission.

The grievance will be investigated by the office manager and a variance report will be written after an investigation is completed. All dates will be noted on the report. All information will be communicated to the Office Manager. The Office Manager will make recommendations on how the grievance should be addressed. As appropriate, the grievance may be presented to the medical director and center's staff. Appropriate actions may include, but are not limited to, a letter to the patient and/or caregiver, and/or a personal phone call.

Alleged Violations and/or Grievances shall include but not limited to:

- Neglect or mistreatment
- Verbal abuse
- Mental abuse
- Sexual abuse
- Physical abuse

Only substantiated allegations will be reported to the state authorities or local authorities as appropriate.

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NOTICE OF PRIVACY PRACTICES

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

We use and disclose PHI for many different reasons. For some of these uses or disclosures, we need your written authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

Uses and Disclosures Which Do Not Require Your Authorization

We may use and disclose your PHI without your authorization for the following reasons:

- **For Treatment.** We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you are being treated for a knee injury, we may disclose your PHI to the physical therapist in order to coordinate your care.
- **For Payment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.
- **For Health Care Operations.** We may disclose your PHI in order to operate this medical center. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.
- **For Disclosure.** When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in a judicial or administrative proceeding.
- **For Public Health Activities**. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information. We may provide coroners, medical examiners, and funeral Administrators necessary information relating to an individual's death.
- **For Health Oversight Activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- **For Research Purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
- **To Avoid Harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- **For Specific Government Functions**. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- **For Workers' Compensation Purposes**. We may provide PHI in order to comply with workers' compensation laws.
- **Appointment Reminders and Health-Related Benefits or Services**. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

Two Uses and Disclosures Require You to Have the Opportunity to Object

- **Patient Admissions** If you are admitted to the center, we may include your name, location in the center, general condition, and religious affiliation, in our patient admission log for use by clergy and visitors who ask for you by name, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

- **Disclosures to Family, Friends, or Others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment of your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

Other Uses of Health Information

In any other situation, not described in this notice, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
- **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request as long as we can easily provide it in the format you requested.
- **The Right to Inspect and Copy Your PHI**. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, what our reasons are for the denial and explain your right to have the denial reviewed.
- **If you request copies of your PHI,** we will charge a base fee. In some cases, instead of providing the requested PHI, we may offer a summary or explanation—provided you agree to this method and the associated cost in advance.

  The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures for:
    - treatment, payment or healthcare operations;
    - information which you have authorized us to disclose;
    - national security;
    - law enforcement as required by state or federal law;
    - information released prior to April 1, 2003.
- **We will respond within 60 days of receiving your request.** The list we provide will include disclosures made in the past six years unless you request a shorter timeframe. It will include the date of disclosure, the recipient (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide this list to you at no charge; however, a base fee may apply for multiple requests within the same year.
- **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed, or (4) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. Your rights allow you to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.
- **The Right to Get This Notice by E-Mail**. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive this notice by e-mail, you also have the right to request a paper copy of this notice.