Connecticut Addiction Medicine
Way to Recovery

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Name:_____Marital Status:_____
Last First Middle

Is this your legal name? YES ☐ NO ☐	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
_____	_____	_____	___/____/____		☐M ☐F

Address: _____
Street City State Zip ☐ Homeless

Social Security no.	Home phone no.:	Cell phone no.:
_____-_____-_____	(_____) _____-_____	(_____) _____-_____

Employment Status: ☐Employed ☐Retired ☐Full-Time Student ☐Part-Time Student ☐Self Employed ☐Unemployed

Occupation _____

Employer Name:_____Address:_____Phone: (_____)_____-_____

Have you ever been treated by our office before? ☐Yes ☐No Other family members seen here: ☐YES ☐NO

Whom:_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

GUARANTOR Name:	Birth date:	Address (if different):	Phone no.:
_____	_____/____/_____	_____	(____)_____-_____

SEX: () MALE () FEMALE

Primary Insurance:	Insurance Address:	Policy #	Group #
_____	_____	_____	

Policy Holders Address: _____

Phone: (_____)_____- _____ SEX: ☐MALE ☐FEMALE

Name of secondary insurance (if applicable):	Insurance Carrier Address:	Policy #	Group #
_____	_____	_____	_____

Patient's relationship to subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐
OTHER_____

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship:	Home Phone Number.:
_____	_____	_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Connecticut Addiction Medicine to release any information required to process my claims.

Patient/Guardian signature:_____ Date:_____

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

PATIENT PAYMENT POLICY

Connecticut Addiction Medicine, LLC Strives to ensure that our patients have a clear understanding of their financial responsibility with respect to the medical services we provide. These policies apply to all procedures and treatments.

INSURANCE: Your insurance policy is an agreement between you and your insurance company. We are not a part to your contract. As courtesy, we will bill your health insurance plan for you, as long as you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage, deductibles, co-pays and similar items.

Non-Contracted Insurances: If we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of costs, but the final amount due will be determined by reimbursement from your insurance company.

Non-Covered Services: Please be aware that some of the services performed by our office, for your benefit, are not covered or may not be considered reasonable or necessary by Medicare or other insurers. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility. Payment will be required prior to your appointment.

INSURANCE CARD: Patients must present a valid insurance card and driver's license (or other form of valid identification) at the time of arrival. It is your responsibility to notify us about insurance changes immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.

CO-PAY: All co-payments must be paid at the time of your visit. This arrangement is a part of your contract with your insurance company. **Failure to pay at the time of service will result in rescheduling of your appointment/group therapy until funds are available.** We reserve the right to refuse treatment to patients who fail to pay the applicable co-pay.

PAYMENTS: We will bill your insurance company as a courtesy to you; but this billing service does not preclude your financial responsibility for the medical treatment received. ***Any deductible, co-insurance or non-covered services, including ineligibility are your responsibility.*** We accept cash, Debit/Credit cards for your convenience. We will send patients accounts to collections for balances not paid after the receipt of two statements unless you make a payment arrangement with our office. We reserve the right to require payment for services to be made at or before the time of service.

PATIENT INITIALS _____

OUTSTANDING BALANCES: We reserve the right to refuse to see patients with outstanding account balances over $100.00 until a payment plan is established with a minimum payment of $25.00/week. Balances over $250.00 will require a minimum payment of $50.00/week. Please be aware that the failure to establish a payment plan may lead to **DISCHARGE** from the practice for non-compliance.

Attestation Statement

I have read, understand, and agree to the above Connecticut Addiction Medicine, LLC Payment Policy.

I understand that changes not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Connecticut Addiction Medicine, LLC to extend credit.

I authorize Connecticut Addiction Medicine, LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____

Print Name of Patient Print Name of Responsible Party if Minor

_____ _____

Signature of Patient (or responsible party if minor) Date

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

PATIENT TREATMENT AGREEMENT

As a participant in the Buprenorphine/Vivitrol program for treatment of Opiate/Alcohol abuse and dependence or for treatment of chronic pain, I freely and voluntarily agree to accept the patient treatment agreement as follows:

- To conduct myself in a polite manner in the physician's office.
- To be present on time for all my scheduled appointments.
- To attend weekly group sessions and be present 15 minutes before the scheduled time to complete urine test.

I understand that **being late more than 5 minutes for a scheduled group** will exclude me from entering group and will be **considered as failure to attend**. (_____) *Initials*

I am informed and understand that if a group is not attended, **a urine for toxicology testing** must be provided **within 24 hours of the scheduled group time**. (_____) *Initials*

Failure to attend a scheduled appointment/group, or positive urine result, will be considered **as non-compliance and will be recorded in the patient chart as a strike**. (_____) *Initials*

Any 3 (three) incidences of non-compliance will be grounds for **DISCHARGE** at the discretion of the provider. (_____) *Initials*

- To take my prescribed medication **as the doctor has instructed** and not to change/modify the way I take my prescribed medication without first consulting the doctor.

The prescribed medication I received is **MY RESPONSIBILTY** and must be kept in a safe, secure place. (_____) *Initials*

I understand that **lost prescriptions for Suboxone will not be replaced**, regardless of the reasons for such loss. (_____) *Initials*

Stolen medication will be **replaced only after supplying the appropriate police report**. (_____) *Initials*

- Not to obtain prescribed medication from any physicians, pharmacies, or other sources without informing my treating physician at Connecticut Addiction Medicine, LLC.

I understand that **mixing buprenorphine with other prescriptions**, especially **benzodiazepines, opioids**, and other drugs of abuse, can be **dangerous**. (_____) *Initials*

I am informed and understand that **deaths have been reported** among persons **mixing buprenorphine with these other drugs**. (_____) *Initials*

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

PATIENT TREATMENT AGREEMENT cont.

- NOT to SELL, SHARE, or GIVE any of my prescribed medication to another person.

I understand that such mishandling of my prescriptions is a serious violation of this agreement and will result in my treatment being **TERMINATED** without recourse for appeal. (_____) *Initials*

- To provide random urine tests, witness or unwitnessed, for verification of compliance with the treatment program.

I understand that falsifying my urinalysis in any way will result in **IMMEDIATE** termination from the program without recourse for appeal. (_____) *Initials*

- To avoid over-the-counter agents that may give a positive urine result (e.g. Poppy seeds, cough/cold medicines containing ephedrine or pseudoephedrine; agents containing alcohol such as some sleep aids, mouthwashes, and after shave lotions).
- To abstain from alcohol, opiates, marijuana, cocaine, and all other substances of abuse, excluding nicotine.
- To provide the medication from active prescriptions for med counts if requested.

I understand and agree that Connecticut Addiction Medicine Office reserves the right to obtain **OBSERVED** urine tests at any time.

I understand and agree that violation of any of the above are grounds for termination of treatment.

Print Name:_____

Signature:_____Date:_____/_____/_____

STAFF USE ONLY

Copy of Agreement given by:_____ Date:_____/_____/_____

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

PATIENT HEALTH HISTORY

Name:_____Date:____/____/____

Date of Birth:_____/_____/_____ Age:_____ Sex:☐MALE☐FEMALE

ALLERGIES:_____

Primary Care Physician:_____
Phone: (_____)_____-_____ Fax: (_____)_____-_____

Which Pharmacy do you use? _____
Phone: (_____)_____-_____ Fax: (_____)_____-_____
Address:_____
Street City State ZIP

Current Medication:_____
_____
_____
_____

Known Medical Conditions:_____
_____
_____
_____

Patient Signature:_____

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Connecticut Addiction Medicine, LLC
546 Cromwell Ave, Suite 101 Rocky Hill CT 06067
330 Main Street, Suite 101 Hartford CT 06106
Jay Benson, MD—Mahboob Aslam, MD

Name of Patient:_____

I hereby acknowledge that I received a copy of this medical practice's notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____ Date:_____/_____/_____

Print Name:_____ Phone: (_____)_____-_____

If not signed by the patient, please indicate your relationship to the patient:

_____

_____

For Office use only:

Signed form received by:_____

Acknowledgment refused:

Effort to obtain:_____

Reason for refusal:_____

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

NON-SMOKING AND NON-LOITERING AGREEMENT

Notice to Connecticut Addiction Medicine, LLC Patients

The entire OUTSIDE premises at 546 Cromwell Avenue have been made

NON-SMOKING and NON-LOITERING

This was done at the request of our practice and the request of the building management.

Please respect this policy.

Violation will affect practice compliance.

Thank you for your cooperation.

Notice Receipt Acknowledgement

Notice to Connecticut Addiction Medicine Patients

In effect: 09/10/2015

I have reviewed the above and agree to adhere to the policy.

Patient Signature: _____Date:_____/_____/_____

Patient Printed Name:_____

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

COMPLIANCE WITH COUNSELOR APPOINTMENTS

Printed Name:_____Date:_____/_____/_____

It is now our practice policy to view attendance at counselor appointments as a measure of practice compliance. Our counselors include nurse practitioners, social workers, and licensed alcohol & drug counselors. A no-call-no-show for such visit will result in the patient subsequently being followed on a zero tolerance basis. The latter means any further missed appointments or positive urine toxicology results will be considered grounds for discharge.

I have read the above and agree to comply.

Patient Signature: _____

Staff Witness: _____

PATIENT INITIALS _____

Connecticut Addiction Medicine
Way to Recovery

OFFICE POLICIES

- **Cancellations and Missed Appointments**- If you miss an appointment or cancel less than 48 hours before the scheduled appointment time you will receive a strike in your chart.

- **Late Arrivals**: In order for our doctor to see their patients in a timely manner, your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office may reschedule your appointment. Tardiness affects your patient care as well as those patients that have scheduled a time after you.

- **Reminder Calls-** The office will call to remind you of your appointment as a courtesy. It is the patient's ultimate responsibility to remember his/her appointment time and group time. We do not call to remind patients of groups.

- **Co-Pay/Balances-** All copay's and balances are due at the time of service in order to be seen by the doctor. If you do not have your copay your appointment will be rescheduled.

- **Insurance Cards/ Photo ID-** We are required to have current copies of your insurance card and photo ID. It is the patient's responsibility to inform office staff if insurance has changed or if a new card was issued. If patient does not present, his/her photo ID and insurance information at the time of the service the entire visit will be rescheduled.

- **Medical Records Request-** A signed authorization must be provided before medical records are reviewed and released. Please allow up to 30 days from request. If you require a compliance letter/attendance letter, please give the office a 24-hour notice.

I _____, understand these policies.

Patient Name:_____Date:_____

Patient Signature:_____

PATIENT INITIALS _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Connecticut Addiction Medicine, LLC

546 Cromwell Avenue, Suite 101 Rocky Hill, CT

330 Main Street, Suite 101, Hartford CT

101 Water Street, Suite 301, Norwich, CT

Jay Benson, MD **Mahboob Aslam, MD**

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). *This Summary is for your convenience and is not a substitute for reading the entire Notice (the next 3 pages) and does not modify the terms of the Notice.*

1. **Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location and general condition. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, medical research, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes as specified by law.

2. **Other Uses and Disclosures**. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **Your Health Information Rights**. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
    a) You may request restrictions on certain uses and disclosures of your information
    b) You may request that you receive your information from us in a certain way
    c) You may inspect and copy your medical records
    d) You may request an amendment to any record you believe is inaccurate
    e) You may request an accounting of disclosures made of your records

4. **Changes to the Notice**. We reserve the right to change the Notice. If we do so, we will post it in our office, [and on our website] and provide a copy upon request.

5. **Complaints**. You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

PATIENT INITIALS _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Connecticut Addiction Medicine, LLC

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

***For Office Use Only*:**

☐ Signed form received by: _____

☐ Acknowledgment refused: _____

Efforts to obtain: _____

Reasons for refusal: _____

PATIENT INITIALS _____

FULL NOTICE OF PRIVACY PRACTICES

Connecticut Addiction Medicine, LLC

Effective Date: 04/01/03

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

We understand the importance of privacy, and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide, and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We may use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. We may also share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

2. Payment. We may use and disclose medical information about you to obtain payment for the services we provide. For example, we may give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information to request that your health plan authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, a health care clearinghouse or health plans that have a relationship with you when they request this information, to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of compliance, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with any of the other health care providers who participate your health plan or network, for any health care operations activities of that plan or network.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information with the person answering the phone or on your answering machine.

5. Sign in sheet. We may ask you to sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to a family member or a close friend or other person you identify where relevant to that person's involvement in your care or payment for your care. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communicating with your family and others.

7. Marketing. We may contact you to give you information about product or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that

   may be of interest to you or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use of disclose your medical information for marketing purposes without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

PATIENT INITIALS _____

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We re also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

14. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record may be transferred the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

15. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.]

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by submitting a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Connecticut law. We may deny your request under limited circumstances.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 7 (notification and communication with family) and 17 (certain government functions) of Section A of this Notice of Privacy Practices or disclosures of data which exclude direct patient identifiers for purposes of research or public health or disclosures which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities and certain other disclosures.

PATIENT INITIALS _____

6. Right to Receive a Notice of Privacy Practices. You have a right to receive a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV-Related Information

Under Connecticut or federal law, additional restrictions may apply to disclosures of health information that relates to care for psychiatric conditions, substance abuse or HIV-related testing and treatment. This information may not be disclosed without your specific written permission, except as may be specifically required or permitted by Connecticut or federal law. The following are examples of disclosures that may be made without your specific written permission:

- Psychiatric information. We may disclose psychiatric information to a mental health program if needed for your diagnosis or treatment. We may also disclose very limited psychiatric information for payment purposes.
- HIV-related information. We may disclose HIV-related information for purposes of treatment or payment.
- Substance abuse treatment. We may disclose information obtained from a substance abuse program in an emergency.

E. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and provide you with a copy upon request. [*For practices with websites add*: We will also post the current notice on our website.]

F. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

You may also submit a complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

PATIENT INITIALS _____