

VICTOR HEALTH ASSOCIATES
6532 ANTHONY DRIVE, SUITE A
VICTOR, NY 14564
585-924-2100
www.victorhealthassociates.com

Dear New Patient:

The providers and staff would like to welcome you to our practice! Victor Health Associates specializes in providing excellent healthcare to patients of all ages.

To help us provide the highest quality care to you, we ask that you complete several forms to collect necessary information about you.

Adult New Patient Forms and Documents List

1) Adult Patient Registration Form: Patient and insurance information is collected using this form, please make sure to complete in its entirety. This also acts as an assignment of benefits and acknowledgement of some key office policies. Please take the time to review and if you have any questions, our staff will be happy to help.

2) New Patient Health History Questionnaire: Please complete all sections and attach additional pages if needed.

3) Authorization for Release of Medical Information: This is so we may obtain medical records on your behalf, to provide the best care, we can. This form should be filled out for any previous doctor you have seen, including specialist or those out of the area. Make sure to complete all required fields and provide a fax number. We will send this form to the physicians or facilities you designate.

4) Patient Portal Activation Letter: We now offer patients the opportunity to access many healthcare functions through our patient portal. Through the portal, patients can communicate to office staff, make, cancel, check appointments, update demographic information, request prescription refills, and much more.

Once you receive your personal Activation Letter, please activate your Portal as soon as possible.

5) Notice of Privacy Practices: This is an important notification that explains how medical information is used and disclosed and how to access your information.

Please arrive at least 15 minutes prior to the scheduled appointment time, and in addition to the completed forms, be sure to bring the following to your first appointment:

- Photo ID
- Current Insurance Card(s)
- Copayment or deductible amount

If your insurance requires you to list a **Primary Care Provider**, please contact them to list the correct physician **prior to your appointment date**. If you have any questions regarding your coverage we suggest you also take that opportunity to ask them directly.

If a conflict should arise and you need to reschedule, a minimum of 24-hour notice is required. We may not re-schedule a missed new patient appointment, or one that has been canceled or re-scheduled with less than the required notice.

Thank you for your cooperation, we look forward to having you with us!

Sincerely,

Providers & Staff of Victor Health Associates

REGISTRATION FORM

VICTOR HEALTH ASSOCIATES
6532 ANTHONY DRIVE, STE A
VICTOR, NY 14564
WWW.VICTORHEALTHASSOCIATES.COM
585-924-2100

Josephine Barrett, M.D.
Kevin D. Penird, M.D.
Brian E. Piotrowski, M.D.
Philip S. Meaker, M.D.

Today's Date _____

ADULT PATIENT INFORMATION

Please assist us by reviewing and completing all sections of this form in its entirety.

First Name _____ MI _____ Last Name _____ Maiden _____

Birth Date ____/____/____ SS# _____ - _____ Gender ___M___F E-Mail _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Previous Primary Care Physician: _____ Reason for Transfer _____

Emergency Contact _____ Phone _____ Relation _____

Preferred Pharmacy (Name/Location) _____

Preferred Lab Facility (Name/Location) _____

Do you have any advanced directives? (if yes, please circle): Living Will Health Care Proxy Orders for Life-Sustaining Treatment (MOLST)

Marital Status Married Divorced Widowed Single

Employment Status Full Time Part-Time Retired Unemployed Employer _____

Student Status Full Time Part-Time N/A

Ethnicity Hispanic Non-Hispanic Decline

Primary Language English Spanish French Other _____

Race White African American Asian Indian Pacific Islander Decline

Insurance Information

Please fill out information completely for each policy. See reverse for more information on patient financial responsibility.

Primary Insurance

Insurance Company _____

Patient ID # _____ Suffix _____

Group # _____ Effective Date _____

Plan Type _____ PCP Listed with Plan: _____

Select: Deductible: \$ _____ Copay: \$ _____

Subscriber Information Patient is Subscriber

Name _____ DOB _____

Subscriber ID # _____ Gender ___M___F

Patient Relation to Subscriber: _____

Secondary Insurance No Other Medical Insurance Coverage

Insurance Company _____

Patient ID # _____ Suffix _____

Group # _____ Effective Date _____

Plan Type _____ PCP Listed with Plan: _____

Select: Deductible: \$ _____ Copay: \$ _____

Subscriber Information Patient is Subscriber

Name _____ DOB _____

Subscriber ID # _____ Gender ___M___F

Patient Relation to Subscriber: _____

If your insurance requires you to list a primary care provider, please update this prior to being seen. Failure to do so may cause insurance rejection. Any outstanding balance as a result will become patient responsibility.

Any copay, coinsurance, or deductible amount collected at the time of check in (if applicable), is an estimate for the cost of the service for that visit based on type of visit and insurance coverage. Although we do our best to be accurate, additional services or procedures, changed information provided to us by patient or insurance, and/or the response received from your insurance plan after submission, may result in an additional balance due. If you have a question regarding your coverage, please contact your insurance company.

Please continue registration form on back of page.

Office Use Only:

ACCT #:
Received Date/Initials:
Reviewed Date/Initials:

**OFFICE POLICY AGREEMENT, NOTICE OF PRIVACY PRACTICES
ACKNOELEDGEMENT & ASSIGNMENT OF BENEFITS**

I, the undersigned, realize that I am financially responsible for all services rendered to me or my dependent. I authorize Victor Health Associates, to apply for benefits on my behalf to my insurance carrier and for payment to be made directly to Victor Health Associates for services rendered to me.

For those insurance plans that Victor Health Associates does not participate with, I realize that I am personally responsible for all co-payments, deductible and non-covered services.

Additionally, I understand:

1. Copayments and coinsurance are due and payable at the time of the visit, as well as charge estimates for deductible plans. (This rule is part of your insurance company contract). A fee of \$25 may be assessed if payment is not made at the time of service and a \$25 fee will be charged for any returned checks.
2. Missed appointments, as well as cancellations and re-schedules within 24 hours of the appointment time, may result in a charge of \$25. Additionally, multiple missed appointments could result in discharge from the practice. New patients will not be charged; however, we will not extend a second appointment to be scheduled.
3. Non-Covered Services are those that may not be covered under certain insurance plans or services provided to individuals without insurance or that are covered by an insurance the providers do not participate with (i.e. Medicaid). If I have no insurance coverage or if my insurance coverage is provided by a company other than one that Victor Health Associates accepts assignment from (including primary or secondary coverage), the cost of all services (or any remaining cost after submission to a policy we do participate with) will be the responsibility of the patient/parent/guardian/guarantor.
4. It is the patient responsibility to inform the office of any changes to contact information or insurance, as well as present a current insurance card at every visit. It is also the responsibility of the patient to provide their insurance with all necessary information needed for the office to bill on their behalf, this includes designating a provider as their PCP if required by their policy. *The full office Financial Policy is available by request.*

I directly assign all medical/surgical benefits to Victor Health Associates and authorize the office to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I have been given a copy of the office Notice of Privacy Practices.

I certify that the information I have provided on this form and any other office forms is correct and that I have read and understand the above, and will comply with office policy.

Signature of Patient	Date
Printed Name of Patient	

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Victor Health Associates for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Beneficiary Signature	Date
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Victor Health Associates

Today's Date: _____ **Adult New Patient Health History Questionnaire**

Patient Name: _____ DOB: _____

Select Primary Care Doctor: _____ Dr. Barrett _____ Dr. Meaker _____ Dr. Penird _____ Dr. Piotrowski

1. What are the top three items you would like to discuss at your initial appointment?
 - a. _____
 - b. _____
 - c. _____

2. Indicate any symptoms which you have had in the past year or now:

Personal Health Information

3) Medication/Drug History

Current Medications: List all prescription and over the counter medications, attach additional pages if needed. Prescription medications must include dosage/frequency/prescriber and bring in medication bottles to appointment.

Name	Dose	Times/Day	Reason	Prescriber
1				
2				
3				
4				
5				
6				
7				
8				

Allergies _____

4) Medical History / Problems

1
2
3
4

5) Specialists/Past Surgeries

Specialists (name/specialty/last seen)	Previous Surgeries/Hospitalizations (include date):
1	1
2	2
3	3
4	4

6) Immunizations: *Please enter the date (or best estimate) of completion and the location.*

Name	Date	Physician/Location
Tetanus		
Shingles		
Pneumonia		
Influenza		
Other: _____		

Activities of Daily Living and Support

- 7) Do you utilize any assistive/support devices to help you get around? (If yes circle type) Yes No
- Cane Walker Wheelchair Hearing Aids Other Communication Aids: _____ Other: _____

Health Maintenance

Colonoscopy Date: _____ Result: _____ Location: _____

Women Only:
 Pap/Pelvic Date: _____ Result: _____ OB/GYN: _____
 Mammogram Date: _____ Result: _____ Location: _____
 Mastectomy Date (if applicable): _____ Partial: _____ Complete: _____

Diabetic Patients:
 Date of Last A1c: _____ Result: _____
 Date of Last Eye Exam: _____ If >1yr, scheduled? _____
 Date of Last Foot Exam: _____ If >1yr, scheduled? _____

Family History – If there is multiple options in the left column, please circle. Use the comments section to add additional details.

Adopted? (Circle): Yes No	Mother	Father	Sister(s)	Brother(s)	Grandmother	Grandfather	Other Relative	Comments
Number of Siblings: _____								
Number of Children: _____								
Deceased? (include age)								
No significant history known								
Alcoholism / Drug abuse (CIRCLE)								
Alzheimer's								
Asthma								
Autoimmune Disease								
Cancer Breast								
Cancer Colon								
Cancer Other Type								
Colon Polyp								
Coronary Artery Disease (heart attack/angina)								
Depression / Suicide / Anxiety (CIRCLE)								
Diabetes (Specify in comments Type I/Type II)								
Emphysema (COPD)								
Glaucoma								
Heart Disease								
Hepatitis								
High Blood Pressure - Hypertension								
High Cholesterol								
Thyroid Disease								
Kidney Disease								
Stroke/TIA								
Other (specify)								

Social History

8) Lives with you in home (mark all that apply):
 ___Children ___Spouse ___Significant Other ___Extended Family: _____ ___Other: _____

9) Are you currently Employed? FT PT No What is your occupation? _____

10) Have you ever been exposed to any chemicals/irritants/hazardous materials at work? Yes No
 Type: _____

11) Have you ever used recreational, street drugs, or prescription medications to get high within the past three years? If yes, circle all that apply: Yes No
 Cocaine Heroin Marijuana LSD/Acid Anabolic Steroids Pain Meds

12) Do you consume alcoholic beverages? Yes No
 a. If you consume alcoholic beverages, how many drinks do you consume per week? _____
CIRCLE: Beer Wine Liquor

Signature of Patient: _____ Date _____

Authorization for Release of Medical Information

Please complete all required sections legibly in blue or black ink in order for us to process this request. **Incomplete or inaccurate forms will not be accepted.**

Patient Name: _____ Date of Birth: ____/____/____
Phone: (____) _____ - _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize *Victor Health Associates* to obtain information from:
Name of Provider/Facility: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) _____ - _____ Fax: (____) _____ - _____

PURPOSE FOR THIS REQUEST: (Check one) ____ Transfer of Care ____ Health Care ____ Other (specify): _____

INFORMATION TO BE DISCLOSED Please check #1 or #2 or #3

- 1) Complete Record - Please answer all by checking Yes or No to the right of each question**
- including alcohol/drug related information ___Yes ___No
 - including information related to treatment for sexually transmitted diseases ___Yes ___No
 - including mental health related information, such as depression, anxiety ___Yes ___No

2) Other _____
AUTHORIZATION VALID FOR: (Check One)

- This request only.
- One year from the date of this authorization **OR** through _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

3) No previous physician medical records to obtain. Explain: _____

I understand that

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form., except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.
- Release of HIV-related information requires additional authorization.

I further realize that under NY State Health Law, Section 17, charging for copies of medical records is permissible, and that the office will charge \$0.75 per page.

Signature of Patient / Legal Representative Date

Print Name and Relationship to Patient (if requester is not the patient): _____

Effective Date: January 1st, 2016

Reviewed: 01/02/2020, 01/03/2017

NOTICE OF PRIVACY PRACTICES

Victor Internal Medicine & Pediatrics, PC
Lauren Brugnoli, Privacy & Security Officer 585-924-2100

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured 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.

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

This medical practice collects health information about you and stores it in a chart on a computer known as an electronic health record/personal health. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We 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 that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we 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. Or we may use and disclose this information to get your health plan to 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 medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses 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 patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, 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 the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.
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 on your answering machine or in a message left with the person answering the phone. Text reminders are also available.
5. **Check-In.** We may use and disclose medical information about you by having you provide demographic information 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 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, unless you had instructed us otherwise, 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. We may also disclose information to someone who is involved with your care or helps pay for your care. 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 communication with your family and others.
7. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information.** We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **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.
10. **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.

11. **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, subject to the limitations imposed by law.
12. **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.
13. **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 or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization.** We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Workers' Compensation.** We may disclose your health information as necessary to comply with workers' 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 are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of 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.
21. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

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, consistent with its legal obligations, 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.

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 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. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other 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, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
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. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
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), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or 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.
6. **Right to a Copy of this Notice.** You have a right to notice of our duties with respect to your health information, including right to a paper copy of this Notice. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of these rights, contact our Privacy Officer.

D. 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 the terms of this Notice currently in effect. 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 a copy will be available at each appointment. We will also post the current notice on our website.

E. 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. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Effective Date: January 1st, 2016

Reviewed: 01/02/2020, 01/03/2017