ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____
DATE OF BIRTH: _____

REGISTRATION INFORMATION

PATIENT INFORMATION

NAME: _____
Last First Middle Initial
ADDRESS: _____
Street City State Zip
TELEPHONE: _____/_____ Okay to leave message: Y N
Home Cell
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: Single__ Married__ Divorced__ Widowed__ STUDENT STATUS: Full-Time __ Part-Time __

EMPLOYMENT STATUS: Full-Time ____ Part-Time ____ Retired ____ Not Employed Outside the Home ____

RESPONSIBLE PARTY INFORMATION

NAME: _____
Last First Middle Initial
ADDRESS: _____
Street City State Zip
TELEPHONE: _____/_____ Okay to leave message: Y N
Home Cell
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____
ADDRESS: _____
Street City State Zip

INSURANCE INFORMATION (Complete both if Primary/Secondary is part of Patient Coverage)

PRIMARY
INSURANCE:_____
ADDRESS: _____
POLICY #: _____
GROUP #: _____ COVERAGE CODE: _____
SUBSCRIBER: _____
SUBSCRIBER D.O.B.: _____

SECONDARY
INSURANCE: _____
ADDRESS:_____
POLICY #: _____
GROUP #: _____ COVERAGE CODE: _____
SUBSCRIBER: _____
SUBSCRIBER D.O.B.: _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE BILLING AGENT OF ANDREA NOWAK, MD, PC, MY INSURANCE CARRIER(S) AND/OR THEIR AGENT(S) FOR PAYMENT OR DIRECT REIMBURSEMENT LESS ANY DEDUCTABLE OR CO-PAY I MAY OWE.

_____
Patient/Parent/Guardian Signature Date

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY

(CIRCLE ONE) Self Partner/Spouse Child Step-Child Foster-Child Grandchild

FOR OFFICE USE ONLY

CLINICIAN: _____ DX: _____

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

PERSONAL HISTORY
(Confidential Information)

ADDRESS: _____
Street City State Zip

TELEPHONE: _____/_____
Home Cell

EMAIL ADDRESS: _____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

EMERGENCY TELEPHONE: _____/_____
Home Cell

Why have you decided to enter treatment now? _____

_____

What are your goals for treatment? _____

_____

What is the source of distress in your life? _____

_____

What are your main strengths and abilities? _____

_____

What are your hobbies and special interests? _____

_____

What are your weaknesses? _____

_____

Do you spend leisure time (check all that apply): ___ Alone ___ with Family ___ with Friends/Peers

At times do you isolate yourself from others? Yes / No

EDUCATION

Highest grade completed: _____ Are you currently in school? Yes / No

If so, where? _____ Major: _____

Are you satisfied with your current level of education? Yes / No Please explain: _____

_____

EMPLOYMENT

Are you employed: _____ Full-Time _____ Part-Time _____ Unemployed _____ Retired

Employer: _____

Are you satisfied with your current position? Yes / No Please explain: _____

_____

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____
DATE OF BIRTH: _____

Are you experiencing any financial difficulties? Yes / No Please explain: _____

RESIDENTIAL SITUATION

Do you live with: _____ Parents _____Significant Other _____ Spouse _____ Alone _____ Other: _____

SOCIAL INFORMATION

Religion: ___ Catholic ___ Protestant ___ Jewish ___ Hindu ___ Muslim ___ Other: _____

Were you raised in a home that practiced the above religion? Yes / No

How important are your religious, spiritual, or faith-based beliefs? _____

MILITARY SERVICE

Have you ever served in the armed forces? Yes / No If so, which branch? _____

Do you have combat experience? Yes / No

LEGAL HISTORY

Have you ever been arrested? Yes / No If so, please explain: _____

Are you currently facing any charges? Yes / No If so, please explain: _____

Are you currently on probation or parole? Yes / No If so, what court and for what reason? _____

_____

FAMILY HISTORY

MARITAL STATUS: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

IF MARRIED: 1st Marriage _____

Age Date # of Children If divorced, provide date

2nd Marriage _____

Age Date # of Children If divorced, provide date

How would you describe your relationship with your significant other? _____

_____

What difficulties have you experienced in your present or past relationships? _____

_____

Have you ever experienced any violence in your relationships (sexual, physical, verbal, or emotional)? Yes / No
If so, please describe: _____

_____

_____

_____

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

FAMILY MEMBER	NAME	AGE	EDUCATIONAL LEVEL	DOES THIS PERSON LIVE WITH YOU?
Spouse/ Significant Other				
Children				
Mother				
Father				
Siblings/Others				

BIOLOGICAL PARENTS WERE: _____ Married _____ Unmarried _____ Separated _____ Divorced _____ Unknown

If parents were divorced, how old were you? _____ Describe how the divorce affected you: _____

_____

How would you describe your relationship with your extended family? _____

_____

If adopted, when were you told? _____

Please indicate (circle) if there is a family history with any of the following:

Substance Abuse Yes / No If yes, who?_____
Mental Illness Yes / No If yes, who?_____
Suicide Yes / No If yes, who?_____
Developmental Disability Yes / No If yes, who?_____
Autism Yes / No If yes, who?_____
ADHD Yes / No If yes, who?_____

PHYSICAL/MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

TELEPHONE/FAX: _____

Last visit to your physician: _____ Reason for last visit: _____

Describe your current general health: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

Are you in any physical pain at this time? Yes / No If yes, please explain: _____

_____

Have you gained or lost weight in the last 30-60 days? Yes / No If yes, how much and why?_____

_____

Do you have any diet or nutritional concerns? Yes / No If yes, please explain: _____

_____

Have you ever binged (excessive or uncontrolled indulgence in food) or purged (self-induced vomiting, use of laxatives)? Yes / No
If yes, please indicate duration and frequency: _____

Do you have any illnesses or medical problems? Yes / No
If yes, please explain: _____

_____

Medical/surgical hospitalization history: _____

_____

CURRENT PRESCRIPTION MEDICATION, OVER-THE- COUNTER MEDICATIONS, HERBAL, AND NATURAL REMEDIES	**DOSAGE**	**FREQUENCY**	**REASON FOR USE**	**PHYSICIAN**

Are you allergic to any medication(s)? Yes / No If so, which one(s)? _____

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

PLEASE CHECK ANY/ALL SYMPTOMS YOU EXPERIENCE

CONSTITUTIONAL SYMPTOMS
____ Recent weight change
____ Fever
____ Fatigue

EARS/NOSE/THROAT
____ Nose Bleeds
____ Bleeding Gums
____ Swollen glands in neck

EYES
____ Eye disease/injury
____ Blurred or double vision
____ Glaucoma

CARDIOVASCULAR
____ Chest pain or angina pectoris
____ Palpitations
____ Shortness of breath walking/lying flat

RESPIRATORY
____ Chronic or frequent coughs
____ Spitting up blood
____ Asthma or wheezing

GASTROINTESTINAL
____ Loss of appetite
____ Nausea or vomiting
____ Painful bowel movements or constipation
____ Frequent diarrhea
____ Rectal bleeding or blood in stool
____ Peptic ulcer

GENIOURINARY
____ Frequent urination
____ Blood in urine
____ Kidney stones
____ Incontinence or dribbling

MUSCULOSKELETAL
____ Joint Pain
____ Difficulty in walking
____ Muscle pain or cramps

INTEGUMENTARY (SKIN)
____ Varicose Veins
____ Rash or itching
____ Change in skin color

NEUROLOGICAL
____ Stroke
____ Convulsions or seizures
____ Frequent or recurring headaches

ALLERGIES/IMMUNE
____ Itchy or runny nose
____ Itchy or running eyes
____ Food intolerances

ENDOCRINE
____ Thyroid disease
____ Glandular or hormone problem
____ Diabetes
____ Change in hat or glove size
____ Heat or cold intolerance

HEMATOLOGIC/LYMPHATIC
____ Slow to heal after cuts
____ Phlebitis
____ Past transfusion
____ Bleeding or bruising tendency
____ Anemia

TRANSMITTED DISEASE
____ Hepatitis
____ HIV
____ Syphilis

Patients are responsible to follow-up with their Primary Care Physician or Specialist if experiencing any of the above symptoms.

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

SUBSTANCE USE AND HISTORY

SUBSTANCE	AGE OF ONSET	AGE AT REGULAR USE	AGE OF LAST USE	AMOUNT USED IN LAST 48 HOURS	AMOUNT USED IN LAST 30 DAYS	HAS AMOUNT USED INCREASED?
Alcohol						
Benzodiazepines (Xanax, Klonopin, Ativan, etc.)						
Cocaine/Crack						
Methamphetamines						
Opiates (Vicodin, Oxycontin, Heroin, etc.)						
Marijuana						
Hallucinogens (PCP, LSD, Mescaline, etc.)						
Inhalants						
Caffeine						
Energy Drinks						
Nicotine						
Other						

BEHAVIORAL HEALTH

Are you now or have you ever thought of or attempted to hurt yourself? Yes / No If so, please explain: _____

_____

Are you now or have you ever thought of or attempted to hurt someone else? Yes / No If so, please explain: _____

_____

Do you have access to firearms or other weapons? Yes / No If so, please describe: _____

MENTAL HEALTH TREATMENT

TREATMENT PROVIDER	PERIOD OF TIME	INPATIENT OR OUTPATIENT	REASON	WHY DID YOU STOP?

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

PAST PSYCHIATRIC MEDICATION USED	DOSAGE	DATES OF USE	RESPONSE TO MEDICATION

Have you ever attended a support group (AA, NA, Grief, etc.)? Yes / No If yes, what group and for how long? _____

_____

Have you ever experienced any: ___ Physical Abuse ___ Sexual Abuse ___ Emotional Abuse ___ Abandonment/Neglect

If yes, by whom? _____

Length/duration of abuse: _____ Age of abuse: _____

IAPT PHOBIA SCALES								
Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.								
0	1	2	3	4	5	6	7	8
Would not avoid it		Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it
1.	Social situations due to fear of being embarrassed or making a fool of myself.							
2.	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness).							
3.	Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).							

GAD-7	Over the past 2 weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Feeling nervous, anxious or on edge.	**0**	**1**	**2**	**3**
2.	Not able to stop or control worrying.	**0**	**1**	**2**	**3**
3.	Worrying too much about different things.	**0**	**1**	**2**	**3**
4.	Trouble relaxing.	**0**	**1**	**2**	**3**
5.	Being so restless that it is hard to sit still.	**0**	**1**	**2**	**3**
6.	Becoming easily annoyed or irritable.	**0**	**1**	**2**	**3**
7.	Feeling afraid as if something awful might happen.	**0**	**1**	**2**	**3**
For office use only	***GAD-7 total score =***				

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

PHQ-9	Over the last 2 weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things.	**0**	**1**	**2**	**3**
2.	Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3.	Trouble falling or staying asleep, or sleeping too much.	**0**	**1**	**2**	**3**
4.	Feeling tired or having little energy.	**0**	**1**	**2**	**3**
5.	Poor appetite or overeating.	**0**	**1**	**2**	**3**
6.	Feeling bad about yourself – or that you are a failure or have let yourself or family down.	**0**	**1**	**2**	**3**
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	**0**	**1**	**2**	**3**
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9.	Thoughts that you would be better off dead or of hurting yourself in some way.	**0**	**1**	**2**	**3**
For office use only	***PHQ-9 total score =***				

STOP! Please sign this document during your meeting with your psychiatrist or therapist.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Signature with Credentials Date

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

CONSENT TO TREATMENT AND CLINICAL SERVICES

I understand that the treatment/services I receive will be based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

I understand that my records are confidential. These records can be released only as allowed by law under statutes of the State of Michigan and Federal guidelines, or by my signature specifying the release of information to a specific individual or agency.

I understand if I threaten to harm ourselves or someone else that State of Michigan statute obligates mental health professionals to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

I understand if I am involved in litigation of any kind and the court is informed of mental health/substance abuse treatment, I may be waving the right to keep records confidential. I further understand I may want to consult with my attorney before disclosing to a court that I am receiving treatment or diagnostic services.

I understand if I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information to the court will be requested. I also understand that any report regarding my myself will not be released until my account is paid in full.

I understand it may be necessary to reach me by mail, email, text, or telephone during or after my treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys, and any necessary follow-up.

I understand that State of Michigan and Federal laws and regulations do not protect any information about suspected child and elder abuse or neglect from being reported to the appropriate state or local authorities.

I acknowledge that I am voluntarily authorizing diagnostic and/or treatment services for myself. I acknowledge I may refuse any aspect of treatment, understanding that such a refusal could, in some instances, result in termination of treatment and/or services.

I have read this consent, received a copy of Andrea Nowak, MD, PC privacy practices and agree to comply with the policies and procedures.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Date

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

BEHAVIORAL HEALTH PROVIDER COMMUNICATION FORM

Patient Consent to Release/Exchange Medical Information (to be completed by patient or parent/guardian)

I, _____, _____, authorize / do not authorize the exchange of information
(Patient Name) (Date of Birth) (Circle One)

between ANDREA NOWAK, MD, PC and: _____
Physician Name

_____
Physician Address City State Zip

_____
Physician Telephone Number / Physician Fax Number

To release/exchange information regarding my mental health/substance abuse treatment and including medical records for coordination of care purposes and as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care diagnosis, treatment, psychotherapy notes, and/or treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my physician.

Requested information: _____
_____
_____
_____
_____

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

Assessment/Admission Date: _____ Diagnosis:_____

Treatment Type: _____ Frequency:_____
(individual, family, group, medication) (weekly, bi-weekly, monthly)

_____ _____
Signature with Credentials Date

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

PATIENT FEES AND PAYMENT AGREEMENT

Usual and customary fees in effect and billed to insurance companies for standard services offered:

Additional services not covered by insurance companies:

Letter writing consultation, form completion	$90.00	(every 20 minutes)
Late cancel or no show fee	$60.00	
Medication refills without appointment	$10.00	

(This in no way implies that an appointment with your psychiatrist is optional or only for emergencies.)

Medical record copying is according to the current State of Michigan rate schedule.

I understand payment for services is due at the time services are rendered. Statements will not be sent for current patients, unless arrangements have been made. I understand any deductibles and co-pays are my responsibility and due at the time of service. I understand any deductible or co-pay applicable to my policy is best explained by my insurance carrier.

I understand there will be a charge of $35.00 for any returned checks. I also understand that ANDREA NOWAK, MD, PC reserves the right to use an outside collection agency as a means of collecting an outstanding balance if my account remains unpaid or payment arrangements are not made. I understand that if my account goes to collections, I will be assessed an additional $25 or 35% collections fee, whichever is greater.

I understand it is my responsibility to keep scheduled appointments or change my appointment online or staff 24 hours prior to scheduled appointment or be charged a $60.00 no show fee/late cancel. This fee is due at the next appointment and cannot be billed to your insurance carrier. In the case of emergencies, your psychiatrist may grant an exception.

Fees are subject to change without notice.

PRIVATE PAY

For patients not utilizing insurance, usual and customary fees of ANDREA NOWAK, MD, PC apply unless a different rate is listed below.

Service Provided _____ $_____

I HAVE READ, UNDERSTAND, AND AGREE WITH THE FINANCIAL CONDITIONS DESCRIBED ABOVE.

_____ _____ _____ _____

Patient/Parent/Guardian Signature Date Witness Date

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR RESPONSIBILITIES

Andrea Nowak, MD, PC (hereinafter referred to as AN) takes the privacy of your/your child's health care information seriously. AN is required by applicable federal and state law to maintain the privacy of your health information. AN is also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your/your child's health information. AN must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 1, 2014, and will remain in effect until AN replaces it.

AN reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. AN reserves the right to make the changes in privacy practices and the new terms of her Notice effective for all health information that is maintain, including health information AN created or received before any changes are made. Before AN makes any significant change to the privacy practices, AN will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact AN using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

AN uses and discloses health information about you/your child's for treatment, payment, and health care operations. For example:

Treatment: AN may use health information about you to provide you with treatment, health care or other related services. We may disclose your health information to doctors or other providers providing treatment to you. Additionally, AN may use or disclose the health information to manage or coordinate treatment or other related services. (Examples of how we might use and disclose health information for treatment purposes include, for a referral to a physician, for a prescription, or for transfer to another clinician.)

Payment: AN may use and disclose your health information to bill and collect for the treatment and services we provide to you. We may send information to an insurance company or other third party for payment purposes.

Healthcare Operations: AN may use and disclose your health information in connection with her healthcare operations. These uses and disclosure are necessary to run AN, to make sure you receive competent, quality health care, and to maintain and improve the quality of health care we provide.

As Required By Law: AN will disclose your health information when required to do so by federal, state, or local law.

For Public Health Purposes: AN may disclose your health information for public health activities. While there may be others, public health activities generally include the following:

- Preventing or controlling disease, injury or disability;
- Reporting problems with medications;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: AN may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government benefit programs and compliance with civil rights laws.

Judicial Purposes: AN may disclose your information in response to a court or administrative order.

Law Enforcement Purposes: AN may release health information if asked to do so by a law enforcement official if such disclosure is:

- Required by law;
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim or a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Covered Entity; or
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

To Avert a Serious Threat to Health or Safety: AN may use and disclose your health information when AN believes it is absolutely necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat or to law enforcement authorities in particular circumstances.

Workers' Compensation: AN may disclose your health information as authorized by, and to the extent necessary to comply with, worker's compensation laws relating to similar programs.

Consent: Your consent may also be required in order for this office to make uses and disclosures of your health information, if required by Michigan law.

Your Authorization: In addition to her use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Persons Involved in Care: AN may release health information about you to a family member, other relative or any other person identified by you who is involved in your/your child's health care. AN may also give information to someone who helps pay for your/your child's care. AN may also tell your family, friends, personal representative or other person responsible for your health care that you are a patient with AN. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your/your child's best interest in allowing a person to pick up medications or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170

NAME: _____

DATE OF BIRTH: _____

Abuse or Neglect: AN may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We will only make this disclosure if you agree, or when required to, or when authorized by law.

National Security: AN may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. AN may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. AN may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail, text, messages or letters. If you do not wish AN to contact you about appointment reminders, you must notify in writing the person listed at the end of this Notice.

OTHER USES OF HEALTH INFORMATION
Other uses and disclosure of health information not covered by this Notice or the laws that apply to AN will be made only with your written consent. If you provide AN authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, AN will no longer use or disclose health information about you for the reasons covered without written authorization. You understand that AN is unable to take back any disclosures she may have already made under the authorization, and that AN is required to retain our records of the care that we provided to you.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that AN provide copies in a format other than photocopies. She will use the format you request unless we cannot do so. You must make a request in writing to obtain access to your health information. AN will charge you a reasonable cost-based fee for expenses such as copies and staff time. AN may also charge you $.50 per page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, AN will charge a cost-based fee for providing your health information in that format. If you prefer, AN may prepare a summary or an explanation of your health information for a fee.
Disclosure Accounting: You have the right to receive a list of instances in which AN or her business associates disclosed your information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 2013. If you request this accounting more than once in a 12 month period, AN may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request a restriction or limitation on the health information AN uses to disclose about you/ for treatment, payment or health care operations. You also have the right to request a limit on the health information AN discloses about you to someone who is involved in you care or the payment for that care. In most cases, AN is not required to agree to your request. If AN does agree, she will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to AN as Privacy Officer.
Alternative Communication: Typically, AN will communicate with you regarding you health care either through your cell phone, text message, home phone, email, USPS mail at your home address. You have the right to request that AN communicates with you or your responsible party about you health care in an alternative way or at a certain location. To request confidential communications, you must make your request in writing to AN as Privacy Officer. AN will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about you health care. To inspect and copy health information that may be used to make decisions about you , you can submit your request in writing or orally to AN as Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and/or supplies associated with your request.
Right to Amend: You have the right to ask AN to amend your health and/or billing information for as long as the information is kept by AN. To request an amendment, your request must be made in writing and submitted to AN asPrivacy Officer. In addition, you must provide a reason that supports your request. AN may deny your request for an amendment if is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for AN;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time.
QUESTIONS AND COMPLAINTS
If you want more information about her privacy practices or have questions or concerns, please contact AN. If you are concerned that she may have violated your privacy rights, or you disagree with a decision she has made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have AN communicate with you by alternative means or at alternative locations, you may file a complaint to AN using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. AN will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. AN will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Andrea Nowak, MD, PC

Telephone Number: (734) 404-7002 Office

Address: 409 Plymouth Rd., Plymouth, MI 48170

This form is for educational use only. It is not to be considered a substitute for legal advice, covering only federal law and not state law.