ANDERSON FAMILY MEDICINE
MARK E. LAWLOR, MD
2211 BROWN STREET
ANDERSON, IN 46016
(765) 640-2100

Dear New Patient,

We are pleased that you have chosen Anderson Family Medicine for your primary care and would like to take a moment to personally welcome you to our practice.

We are a full service family practice specializing in the care of patients of all ages. Our business hours are Monday – Thursday from 8:00 AM to 4:00 PM and Friday 8:00 AM to 1:00 PM. Patients are seen by scheduled appointment only. Typically, we have a limited number of same-day appointments available; please call early if you have an acute problem.

We are affiliated with St. Vincent–Anderson Regional hospital, but are not owned or directly managed by the St. Vincent system. Therefore, we can refer you to the specialist of your choosing, should the need arise. If you require hospitalization, we will be available to personally attend your hospitalization at St. Vincent-Anderson, where we have staff privileges.

In order to make your first visit more effective, please complete the following forms included this packet:

1. Consent to Disclose Protected Health Information - Allows us to discuss your condition with other providers and to send information to your insurance company)
2. Consent to Share Protected Health Information - You list people who we have permission to talk to about your medical conditions, i.e. family members or other healthcare representatives.)
3. Insurance Release/Medicare/Patient Responsibility – Outlines our role in helping you file insurance claims, and your responsibilities in the event of a claim denial.
4. Medical Record Release Authorization Form – so we can obtain your prior medical records from your previous provider
5. Receipt of Notice of Privacy Practices.

When you arrive for your first appointment, please bring the following with you:

1. All of your health insurance cards (we will ask for them at every visit).
2. Photo identification: current driver's license, passport or other state photo ID card.
3. All medications you are currently taking, including vitamins and over the counter medications.

Please call our office if you have any questions or need to reschedule your first appointment. We do require a 24-hour notice if you are unable to keep a scheduled appointment. If there are ever any questions or concerns regarding any aspect of your medical care, please feel free to contact us at the number above.

Sincerely,
Mark E. Lawlor, MD
Medical Director

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PATIENTS WITH CHRONIC PAIN

Due to the complex medical and legal issues involved, since the implementation of state laws regulating the prescribing of narcotics in Indiana, our ability to treat patients with chronic non-cancer related pain may be limited. Specifically, the laws mandate a strict limit on the number and strength of opiate/narcotic pain medications which can be prescribed in a certain period of time by a non-specialist.

Therefore, if your condition requires narcotic pain medication in excess of this restriction, your care will be transferred to an appropriate specialist who will assume management of this aspect of your treatment.

If there are any questions or concerns regarding this matter, please call our office at 765.640.2100.

Anderson Family Medicine Prescribing Procedures

We are pleased to provide our patients with state-of-the art electronic prescribing, and take pride in our ability to respond to our patients refill requests with same-day or (at the latest) next-day response times. We would like to introduce you to our medication philosophy and procedures regarding your prescription management.

YOU ARE IN CONTROL OF YOUR MEDICATION

We will assist you whenever possible with your medication management, but in the end, only you can really control what medicines you take! For this reason, we ask our patients to carry a current medication list with them, or bring their medicines (in their bottles) with them to every appointment. We keep a current medication list in our electronic medical record for every patient; however, many patients have more than one doctor who prescribes for them, and sometimes medications can get switched during an emergency, or by accident at the pharmacy. Please make us aware any time a change is made, so we can keep your list up to date.

YOU ARE IN CONTROL OF YOUR REFILLS

When you have refills remaining on your prescription, please contact your pharmacy to refill the medicine. **If there are no refills remaining, YOU should contact us directly**. Often we time prescriptions to expire when you are due for an appointment, and the expiring prescription serves as your reminder.

Many pharmacies have "no worry" or "automatic refill" programs, or will tell you they will contact us when you run out of refills. *Here's how this really works*: They send us a fax. Unfortunately, we receive dozens of faxed refill requests every day which are automatically generated by pharmacy computer systems, and we are unable to determine if the request was generated by you, or by the computer in error, which happens a lot more than it should.

We would like to be able to call patients individually to confirm these refill requests, but due to the sheer number we receive, we regret we are unable to do this. We do tell pharmacists if they personally call that we need to hear from the patient directly to confirm they really need the refill.

We understand this may mean some additional work for you, but for the sake of medical safety we feel it is worth the small inconvenience. We have heard so many stories of patients receiving the wrong medication because of a computer error at the pharmacy, we felt taking this extra step is worth it to our patients.

Because of these risks associated with these automated refills, we strongly advise patients not to participate in such "no worry" refill programs, especially the ones which automatically bill your credit card for mail order pharmacies. You should check their return policy – we have not heard of a single pharmacy which will allow you to return a medication once shipped, and if they have billed your credit card for a medicine you don't need, you may be stuck without any recourse.

CONFIRM YOUR SHIPMENT

For mail order pharmacies, if we prescribe your medicine electronically, we place a request on every prescription for the pharmacist to contact you personally to confirm the name, dose and price of the medication they are shipping to you. Sadly, this doesn't occur every time, and rarely patients will receive the wrong medication. If this happens, please ask the pharmacist to pull the original request and confirm that you did not hear from them prior to shipment. While they are not permitted to accept the medication back from you in return, sometimes this will put the responsibility on them to replace the erroneous prescription.

THE RISING COST OF MEDICATIONS

Our prescribing philosophy is to recommend medications on the basis of medical need, choosing the best medication for your condition and not based solely on the cost of the medication. We understand, however, that price can be a factor and there may be times you may want to try a less expensive alternative. Depending on the condition and the medicine in question, we may be able to handle this request over the telephone, but in certain circumstances the issues related to dosing, side effects and safety profile, we may require a face-to-face discussion regarding the risks of changing medications. Please call us first, and we will let you know how best to handle your request.

WHEN YOUR PHARMACY OR INSURANCE COMPANY WANTS TO CHANGE YOUR MEDICATION

We commonly receive requests directly from your pharmacy or insurance company asking us to change your medication for non-medical, cost reasons. Sometimes they have discussed this with you, and sometimes they have not and are doing so without your permission. Sometimes the difference between the drugs may only be a few dollars, and you might wish to pay the extra amount for the "better" drug we prescribed. For this reason, we always like to give our patients the option to personally manage the medication we have chosen for them, and decide for themselves if the switch is acceptable.

If a pharmacist calls our office to request a change in your medication, we will ask them to have you call us directly for permission to make this switch.

They will be able to give you more information regarding any price differences between the medications in question. If you have any questions with regards to what medications your insurance may or may not cover ahead of time, please contact your pharmacist or insurance company, who will have an up-to-date list

ANDERSON FAMILY MEDICINE, P.C.
2211 BROWN ST
ANDERSON, IN 46016
765-640-2100

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I UNDERSTAND THAT ANDERSON FAMILY MEDICINE, P.C. MAY USE AND DISCLOSE MY PERSONNEL HEATH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I ALOS ACKNOWLEDGE THAT I HAVE RECEIVED, HAVE BEEN OFFERED, OR HAVE RECEIVED IN THE PAST A COPY OF THE PRACTICE'S NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES INFORMATION ABOUT HOW THE PRACTICE, AND INDIVDUALS INVOLED IN MY CARE IN THE PRACTICE MAY USE MY PHI. AS PROVIDED IN THE NOTICE, THE TERMS OF THE NOTICE MAY CHANGE. TO OBTAIN A COPY OF ANY CURRENT NOTICE, I UNDERSTAND THAT I CAN CONTACTTHE PRIVACY MANAGER AT 765-640-2100 OR 2211 BROWN ST, ANDERSON, IN 46016

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST THAT THE PRACTICE RESTRICT HOW MY PHI IS USED OR DISCLOSED FOR TREATMENT, PAYMENT, OR HEATLHCARE OPERATIONS. I ALSO UNDERSTAND THAT THE PRACTICE IS NOT REQUIRED TO AGREE TO A RESTRICITION. HOWEVER, IF THE PRACTICE DOES AGREE, IT IS BOUND BY THAT AGREEMENT. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANYTIME. EXECPT TO THE EXTENT THAT THE PRACTICE OR INDIVIDUALS INVOLVED IN MY CARE IN THE PRACTICE HAVE ALREADY USED OR DISCLOSED PHI IN RELIANCE ON MY PRIOR CONSENT.

_____ _____

SIGATURE-PATIENT/LEGAL REPRESENTATIVE DATE

ANDERSON FAMILY MEDICINE, P.C.
CONSENT TO SHARE PROTECTED HEALTH INFORMATION

THIS DOCUMENT GIVES US PERMISSION TO DISCUSS YOUR PRIVATE HEALTH INFORMATION WITH MEMBERS OF YOUR FAMILY, FRIENDS, OR OTHER PERSONS NOT DIRECTLY RELATED TO THE DELIVERY OF YOUR CARE.

PATIENT NAME _____

SOCIAL SECURITY # _____

I authorize Mark E. Lawlor, M.D. And/or staff at 2211 Brown St., Anderson, IN 46016 to disclose medical information of the above named patient as described below. This authorization is only valid at this location.
Please list all people who may receive personal medical information about you.

MY INFORMATION MAY BE DISCLOSED TO THE FOLLOWING INDIVIDUALS.

NAMES:

_____ _____

_____ _____

_____ _____

I UNDERSTAND THIS INFORMATION MAY BE RELASED VIA FAX, VERBAL COMMUNICATION, PHONE, VOICEMAIL AND/ OR DIRECT MAIL.
ALL CLINICAL AND BILLING INFORMATION __X___ YES____ NO

IF CERTAIN INFORAMTION IS NOT TO BE RELEASED PLEASE LIST:

YOUR RIGHTS WITH RESPECT TO THIS AUHORIZATION:
I understand that I have the right to inspect or copy health information that I have authorized to be used or disclosed by this form as provided in cfr 164.524. I understand that if I agree to sign this release, which I am not required to do, I will be provided with a signed copy of the form upon request. I understand that I have the right to withdraw this authorization at any time. I understand that if I withdraw the authorization I must do so in writing and present my written request to the staff of Anderson Family Medicine, P.C. I understand the withdrawal will not apply to the information that has been released in response to this authorization. I understand that the withdrawal of this will not apply to my insurance company when the law provided my insurer with the right to contest a claim under any policy. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. If I have questions, I can contact Anderson Family Medicine, P.C. Privacy officer at 765-640-2100.

_____ Date _____
Signature of Patient or Legal Representative

_____ Relationship to patient if signed by other

ANDERSON FAMILY MEDICINE

DR. MARK LAWLOR
2211 BROWN ST
ANDERSON, IN 46016
765-640-2100

MEDICARE/MEDIGAP RELEASE

I REQUEST THAT PAYMEN OF AUTHORIZED MEDICARE BENEFITS AND MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ANDERSON FAMILY MEDICINE, P.C. FOR ANY SERVICES PROVIDED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (AND IT'S AGENTS) ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR SERVICES.

_____ _____

SIGNATURE-PATIENT/GUARANTOR DATE

INSURANCE RELEASE/ PATIENT RESPONSIBILITY

I HEREBY AUTHORIZE ANDERSON FAMILY MEDICINE, P.C. TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED TO ME. I REQUEST THAT PAYMENT OF THE AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ANDERSON FAMILY MEDICINE, PC. FOR SERVICES PROVIDED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE ANDERSON FAMILY MEDICINE, P.C. TO RELEASE ANY INFORMATION ACQUIRED TO ESTABLISH A HEALTH INSURANCE CLAIM. I AUTHORIZE THIS OFFICE TO OBTAIN PREVIOUS MEDICAL RECORDS FROM OTHER PHYSICIANS AND/OR MEDICAL FACILITIES INCLUDING BUT NOT LIMITED TO INFORMATION REGARDING TREATMENT OF DRUG AND ALCHOL ABUSE, PSYCHOLOGICAL CONDITIONS, HIV TESTING OR AN AIDS RELATED CONDITION.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES INCLUDING DEDUCTIBLES, CO-PAYMENTS, NON COVERED SERVICES, AND ANY AMOUNT NOT COVERED BY MY INSURANCE EXCEPT IN THE CASES OF A CONTRACTUAL AGREEMENT BETWEEN MY INSURANCE CARRIER AND ANDERSON FAMILY MEDICINE, P.C. I UNDERSTAND THAT SHOULD COLLECTION PROCEEDINGS BECOME NECESSARY, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES, ATTORNEY FEES, AND COURT COSTS.

_____ _____

SIGNATURE-PATIENT/GUARANTOR DATE

*IN CASE OF A CHILD WHOSE RESPONSIBLE PARTY IS SOMEONE OTHER THAN A CUSTODIAL PARENT, WE ASK PAYMENT BE MADE AT THE TIME OF SERVICE BY THE PERSON ACCOMPANYING THE CHILD.

ANDERSON FAMILY MEDICINE, PC

Mark E. Lawlor, MD
2211 Brown Street Anderson, IN 46016 (765) 640-2100

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

RELEASE RECORDS FROM: **RELEASE RECORDS TO:**

_____ _____

_____ _____

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following: _____

☐ My health information for the date(s):_____

☐ Other:_____

You may disclose this health information to:

Name and organization_____

Address: _____City:_____State:_____Zip_____

Reason(s) for this authorization (check all that apply):

☐ at my request

☐ other (specify)_____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.
I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Revocation may be completed by sending a letter to the address above. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES SIXTY DAYS AFTER IT IS SIGNED.

ANDERSON FAMILY MEDICINE, P.C.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

If you have any questions about this notice, please contact our privacy officer.

Effective date: September 23, 2013

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you

that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or

disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your

health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Privacy Officer, Anderson Family Medicine, PC 2211 Brown Street, Anderson, IN 46016. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.andersonmed.com To obtain a paper copy of this notice, please contact the Privacy Officer, Anderson Family Medicine, PC 2211 Brown Street, Anderson, IN 46016.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

ANDERSON FAMILY MEDICINE, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Anderson Family Medicine's Notice of Privacy Practices.

_____ _____
Signature of Patient Date