Jersey Joint, Spine, & Regen LLC
Specializing in Joint Care, Spine Treatments, & Regenerative Medicine

Gerald M. Vernon, DO
Main: (732) 858-6638 - Fax: (732) 399-5463 - Email: info@jerseyjsr.com

479 Newman Springs Road, Building A, Suite 203, Marlboro, NJ 07746

Patient Demographics Form

Name: _____ Age: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile: _____

Email: _____ Gender at Birth: [ ] Male [ ] Female

Do you identify as: [ ] Male [ ] Female [ ] Other Preferred pronouns: _____

Race (optional): _____ Marital Status: ____ S ____ M ____ D ____ W

Last 4 Digits SSN: XXX - XX - _____

Spouse/Significant Other Name: _____ Phone #: _____

Employer Name: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Address: _____

Phone #: _____

Primary Insurance: _____

Subscriber ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Policy Holder DOB: _____

Secondary Insurance: _____

Subscriber ID#: _____ Group#: _____

Policy Holder: _____ Relationship: _____

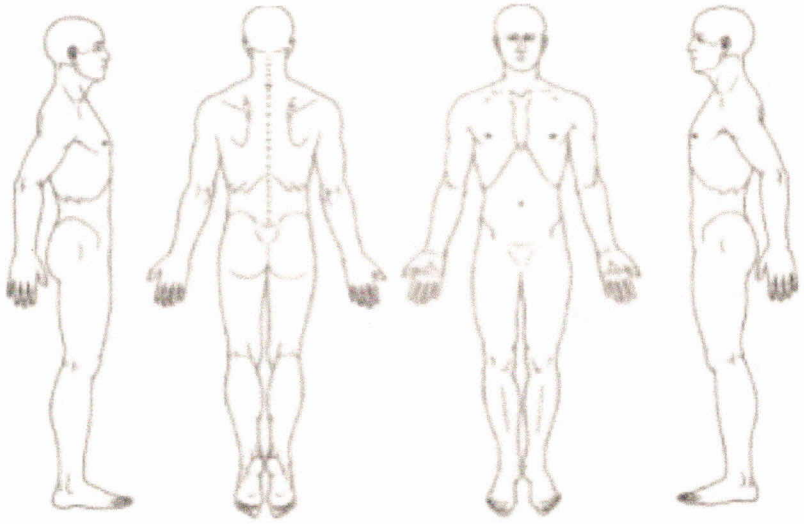
Policy Holder DOB: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____

Pain Information Questionnaire

Mark any pain location with "X" on diagram:



All pain location(s) from worst pain to least: _____

How did it start?: _____

Duration: _____

Constant or spontaneous?: _____

Intensity (circle): **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Quality of Pain (circle): dull aching cramping burning shooting stabbing sharp

Numbness or tingling: If yes, where?: _____

Radiation/travel of pain?: _____

What activities make your pain worse? (circle): standing sitting walking bending forward or backward

bathroom use other: _____

What makes pain better?: _____

Other associated symptoms: _____

What imaging studies have you had (circle): X-ray CT Scan MRI **EMG** Other: _____

DATE **BODY PART** **FACILITY** **PHONE #**_____

_____

_____

_____

Conservative treatments received (circle): PT OT Chiropractic Massage Acupuncture **Other:**

_____

Interventional treatments received: _____

Name and Phone # of other Doctors and/or Surgeons you have seen for this issue:

_____

_____

_____

Patient Signature: _____ **Date:** _____

Past psychiatric history:

_____

_____

Any Implants/Devices (pacemaker, SCS, defibrillator, etc.):

_____

_____

PAST MEDICAL HISTORY No Known Medical Problems ☐

- ☐ Adrenal Disorders
- ☐ Alcohol Abuse
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bipolar Disorder, Nos
- ☐ Breast Disorders
- ☐ Cancer, place (please specify)
  _____
- ☐ Constipation
- ☐ Congestive Heart Failure
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Cystitis
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ DVT
- ☐ Emphysema
- ☐ Epilepsy & Seizures
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gastric Ulcer
- ☐ Glaucoma
- ☐ Gum & Periodontal Disease
- ☐ Gynecologic Disorders
- ☐ Headache
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Hepatitis B Virus (Serum)
- ☐ Hepatitis C Virus
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Infection
- ☐ Irritable Bowel Syndrome
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Peripheral Vascular Disease
- ☐ Prostate Disorders
- ☐ Reflux (GERD)
- ☐ Renal Insufficiency
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis
- ☐ Skin Disorders
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorders
- ☐ TIA (mini stroke)
- ☐ Underweight
- ☐ Misc: _____
  _____
  _____

PAST SURGICAL HISTORY No Known Surgery ☐

- ☐ Abdominal Surgery
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Breast Surgery
- ☐ Bladder Surgery
- ☐ Cervical Fusion
- ☐ Cesarean Section
- ☐ Cholecystectomy (gallbladder)
- ☐ Digestive System Surgery
- ☐ Ear Surgery
- ☐ Endarterectomy
- ☐ Eye Surgery
- ☐ Gastric Surgery
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Kidney Surgery
- ☐ Liver Surgery
- ☐ Oral Surgery
- ☐ Prostate Surgery
- ☐ Skin Surgery
- ☐ Surgery for Aneurysm Repair
- ☐ Throat Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Thoracic Fusion
- ☐ Vertebro/kyphoplasty
- ☐ Lower Back Surgery
- ☐ Right Shoulder Surgery
- ☐ Left Shoulder Surgery
- ☐ Right Wrist Surgery
- ☐ Left Wrist Surgery
- ☐ Right Hand Surgery
- ☐ Left Hand Surgery
- ☐ Right Hip Surgery
- ☐ Left Hip Surgery
- ☐ Right Knee Surgery
- ☐ Left Knee Surgery
- ☐ Ankle Surgery
- ☐ Misc: _____

SOCIAL HISTORY

MARITAL STATUS

- ☐ Never Married
- ☐ Engaged
- ☐ Married
- ☐ Remarried
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

LIVING SITUATION

- ☐ Living Homebound
- ☐ Living with Parents
- ☐ Living with Relatives *(not parents)*
- ☐ Living alone - no help available
- ☐ Living alone - help available
- ☐ Living with Adult Children
- ☐ Living Independently with Spouse
- ☐ Living with a Friend
- ☐ Living with Family

WORK STATUS

- ☐ Working Full-Time
- ☐ Working Part-Time
- ☐ Applying For Disability Comp
- ☐ Currently On Partial Disability
- ☐ Retired
- ☐ Unemployed
- ☐ Never Substantially Employed
- ☐ Currently on Permanent Disability

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MEDICAL HISTORY

Patient name: _____ DOB: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Add additional page if needed):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

Medications: _____ Reaction: _____

Food: _____ Reaction: _____

Latex: _____ Reaction: _____

Other: _____ Reaction: _____

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CONSENT TO TREAT

Patient Name (print)_____DOB:___/___/_____

I hereby authorize Jersey Joint, Spine, and Regen, LLC through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my condition. This treatment will be rendered by a licensed medical doctor.

I understand that I have the right to refuse any procedure or treatment and that I have the right to ask questions about any treatment or examination I have received. I understand that no guarantees can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon the facts known. Lastly, I understand that it is imperative that I communicate to my provider any aggravation or injury that may have occurred during my treatment, whether inside or outside the facility.

I have read the above and understand the risks and benefits of receiving medical care and treatment from the facility.

Signature_____ Date_____/_____/_____

Relationship if Not Patient _____

I further authorize Jersey Joint, Spine, and Regen, LLC to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature_____ Date_____/_____/_____

Relationship if Not Patient _____

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PO BOX 100
BRIELLE, NJ 08730

Main #: (732) 858-6638
Fax #: (732) 858-6638

LETTER OF PAYMENT AUTHORIZATION

Patient Name: _____ Date: _____

I hereby instruct and direct_____
Insurance Company to pay by check made payable to:

Jersey Joint, Spine, & Regen LLC

If my current policy prohibits direct payment to my doctor, I hereby instruct and direct you to make the check payable to Jersey Joint, Spine, & Regen LLC and mail to the P.O. Box stated above, for the professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy towards the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay the balance of said professional service charges due after the insurance payment.

A copy of this assignment shall be considered as effective and valid as the original. I, authorize Jersey Joint, Spine, & Regen LLC on my behalf, to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____
Signature of Member/Patient or Legal Representative

_____
Name of Designated Representative & Title

_____
Signature of Witness

Effective 08/25/2023

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AUTHORIZATION TO RELEASE MEDICAL BENEFIT

RE:_____

DOB:____/____/_____

ID#:_____

I authorize the holder of the following benefit information (e.g., Employer's Benefits Representative, Insurance Provider Service Representative, etc.) to release copies of the following documents to Jersey Joint, Spine, & Regen LLC, in detail:

[X] Summary Plan Description (SPD)
[X] Plan Claim Appeal Procedure
[X] Identification of the Fund, Plan Administrator, Claim Administrators
[X] Full explanation of Medical Benefits

_____	_____	[ ]
Printed Name	Relationship to Patient	Self
_____	_____	
Patient or Responsible Party Signature	Date	

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AUTHORIZATION TO OBTAIN HEALTH INFORMATION FROM ANOTHER MEDICAL PROVIDER

Doctor's Name:_____ Date:___/___/_____

Patient Name:_____ Date of Birth:___/___/_____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider, _____, to use or disclose my health information during the term of this authorization to the receipt I have identified below.

Recipient: My health care provider may disclose my health information to:

Jersey Joint, Spine, & Regen
Address & fax number above for the_____ location

Purpose: The information below is disclosed for the purpose of continued medical treatment. Disclose the following information for treatment dates from ____/____/_____ to ____/____/_____

___ Complete Record
___ Consultation/Evaluations
___ Procedure Reports
___ Diagnostics (X-Rays, MRIs, etc)
___ Laboratory Reports
___ Operating Reports
___ Therapy Notes
___ Discharge Summary
___ Prescriptions
___ Billing
___ Narratives
___ Other, Please Specify: _____

_____ ____/____/_____ _____ ____/____/_____
Signature Date Signature of Witness Date

If the patient is not the person executing this authorization, please complete the information below:

_____ _____
Legal Relationship Patient Name

Jersey Joint Spine & Regen, LLC
Dr. Gerald M. Vernon
479 Newman Springs Road
Building A Suite 203
Marlboro, NJ 07746
Telephone: 732-858-6638 Fax: 732-399-5463

Patient Image & Likeness Authorization & Release (New Jersey)

Practice Name: Jersey Joint Spine & Regen
Treating Physician: Dr. Gerald M. Vernon

Patient Information

Patient Name:

Date of Birth:

Parent/Guardian (if minor):

Permission for Use (check all that apply):

- ☐ Practice website
- ☐ Social media platforms
- ☐ Online / digital advertising
- ☐ Printed marketing materials

Authorization

I authorize Jersey Joint Spine & Regen and Dr. Gerald M. Vernon to capture and use my image and likeness for the purposes selected above. My care will not be affected.

Duration of Authorization

This authorization has no expiration date and remains in effect unless revoked in writing.

HIPAA Authorization

I understand images may be Protected Health Information (PHI). Revocation does not affect prior use.

Revocation of Authorization

Jersey Joint Spine & Regen, Attn: Privacy Officer, admin@jerseyjsr.com

Patient / Guardian Signature (draw or sign electronically):

Printed Name:

Date:

Internal Staff Witness (office use only)

Witness Name:

Witness Signature:

Witness Date:

Governing Law: This authorization is governed by the laws of the State of New Jersey.

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MARKETING AUTHORIZATION FORM

Patient Name: _____ Date: _____

1. Authorizing marketing communication from this practice means I may:

    a. Receive treatment communications concerning treatment alternatives or other health related products or services.
    b. Be contacted for appointment reminders or information about treatment alternatives or other related benefits and services that may interest me.
    c. Monthly updates on the practices pertaining to new services or happenings or events.

    ** I understand that I have the right to "opt out" of receiving such communications.

2. Marketing Authorization Options:

    I wish to receive Marketing Communications from the Practice ONLY
    I wish to receive Marketing Communications from the Practice and this Practice's Business Associate(s)
    I do NOT wish to receive any Marketing Communications

Communications that encourage you to use our services is considered marketing. If we intend to use or sell PHI for personal gain or commercial advantage, we must first obtain written authorization from you.

_____ ____/____/_____
Signature Date

I authorize the practice to communicate with me about my appointments through the following means:

____ Telephone/leaving messages (home / cell / work) ____Text Message ____ E-mail

**circle all that apply

My preference for communications regarding my appointment is: Phone / Text / Email
(please circle one)

*Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices.

Effective 08/25/2023

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.