Shon Cook, M.D. **Patient Information** ***Please complete all information***

Are you claiming this as an on-the-job injury? □ Yes □ No *If yes, stop and fill out the Work Comp form instead.

Name ______ First Middle Last **M F** Sex ___ / / DOB ___ Age

Address ______ Street Address City State Zip

Home ( ) - ______ Cell ( ) - ______ Email ______ SS# - -

Patient Employer ______ Job Title ______

Employer Address ______ Street Address City, State Zip ( ) - Employer's Phone

Do you have a primary care doctor? □ Yes □ No Who? ______

Were you referred to our office? □ Yes □ No By whom? ______

If not, how did you learn about us? ______

Who should we contact in case of an emergency? ______

______ Contact Address City, State Zip ( ) - Contact Phone

If Patient is a Minor, Responsible Party

Name ______ Relationship ______ SS# - -

Address ______ Street Address City, State Zip ( ) - Phone

Employer ______ Occupation ______

Employer Address ______ Street Address City, State Zip ( ) - Employer Phone

Health Insurance Information

Insurance Company ______ Policy Holder ______

Insurance Address ______ Street Address City, State Zip ( ) - Insurance Phone

Policy # ______ Group # ______

Was the problem caused by an accident? □ Yes □ No Date: ______

Do you have an attorney handling this claim? □ Yes □ No Who? ______

Required Authorizations ***Please take a moment to complete all of the following required consents***

1) Consent for Treatment: I hereby consent to an examination and/or treatment as may be deemed necessary by Dr. Cook.

Signed (patient or parent of minor) ______ **Date:** ______

2) Benefits to Physician: I hereby authorize payments directly to Dr. Cook of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (patient or parent of minor) ______ **Date:** ______

3) Release of Information: I hereby authorize release of information necessary for filing my insurance claim, and for insurance claim reviews.

Signed (patient or parent of minor) ______ **Date:** ______

4) I authorize practice/billing company to contact me about my bill regarding medical services provided.

May we contact you by: phone? yes □ no □ cell phone? yes □ no □ work phone? yes □ no □ mail? yes □ no □

5) I have received a Notice of Privacy Practices from the office of Dr. Cook.

Signed (patient or parent of minor) ______ **Date:** ______

6) I have signed the patient consent for use and disclosure of protected health information from the office of Dr. Cook.

Signed (patient or parent of minor) ______ **Date:** ______

You may speak with the following person/s about my bill regarding medical services provided:

Name: ______ **Relationship:** ______ **Phone:** ( ) -

Name: ______ **Relationship:** ______ **Phone:** ( ) -

You may not speak with the following person/s about my bill regarding medical services provided:

Name: ______ **Relationship:** ______

PATIENT MEDICAL HISTORY

Please answer every question as accurately as possible, even if it does not seem relevant.

Name: ____ Date: ________________________

Describe in detail the symptoms you would like addressed today: ________________________________

____

____

Is your pain worse in your neck/back or your arms/legs? ______% neck/back ______% arm/leg

How long have you been experiencing this pain: this episode: ______________ ever: _______________

When do you most often experience your pain? ____morning ____ afternoon ____evening ____night

What activities or specific movements cause or worsen your pain? _______________________________

____

On a scale of 1 (No pain) to 10 (Worst pain imaginable), circle the number that best describes your pain:

Now: 1 2 3 4 5 6 7 8 9 10 At its worst: 1 2 3 4 5 6 7 8 9 10

Have you noticed any weakness? If so, where? ____

Do you have any bowel or bladder incontinence? ____

Do you experience any other symptoms with your pain? If so, what? ____________________________

____

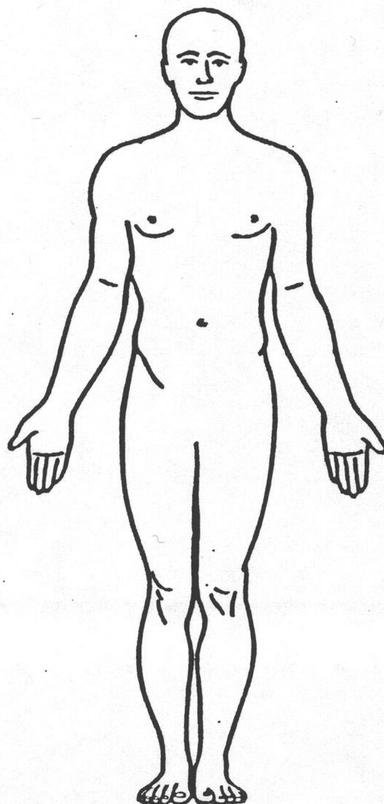
Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation by using arrows and include all affected areas.

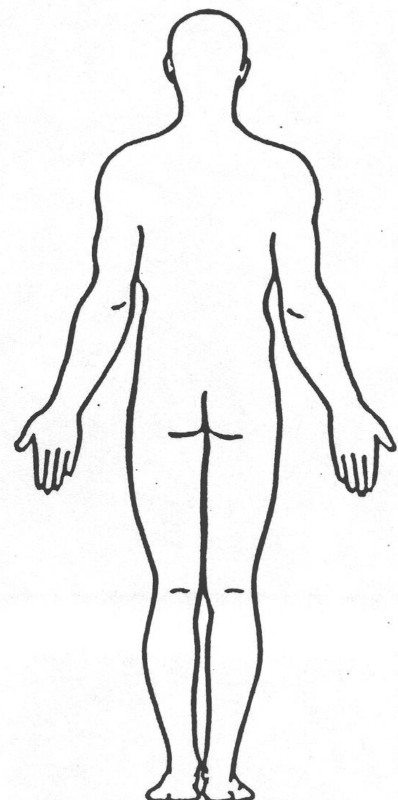
NUMBNESS:
______
______
______

PINS AND NEEDLES:
OOOOO
OOOOO
OOOOO

BURNING:
XXXXX
XXXXX
XXXXX

STABBING:
///////
///////
///////





PATIENT MEDICAL HISTORY

Did your symptoms start after a specific injury? _____Y _____N If so, date of injury: _______________

Briefly describe how and where the injury happened: ____

Were you knocked unconscious? _____ Yes _____No **Auto accidents only**: Were seat belts in use? Y N

Do you have an attorney for this problem? ____Yes ____No

If so, please list name, address and phone number: ____

Have you had a previous on-the-job-injury? ____ Yes ____No If "Yes," when? ___________________

Have you ever received compensation for work-related injuries in the past? ____Yes ____ No

If "Yes," when? _____________________

Have you had diagnostic studies done *for this problem*? If so, fill out below.

TEST	Date:	Facility:
X-Rays		
CT Scans		
MRI		
EMG/NCS		
Discography		

Have you tried any *non-surgical* therapies for this problem yet? If so, fill out below.

Therapy	Date:	Facility/ Doctor:
Physical Therapy		
Chiropractics		
Pain Management		
Other: ________________		

List in order of occurrence all *surgeries* you've had for your current problem.

Surgery	Date	Doctor	Hospital	Improvement?

PAST MEDICAL HISTORY:

List any medical conditions/ surgeries NOT related to your current problem.

Condition/Surgery	Doctor	Date (approx)	Injured area of body	Work Related?	Impairment	Auto accident
					%	Y N
					%	Y N
					%	Y N
					%	Y N
					%	Y N

WOMEN ONLY: Are you pregnant now? ___Yes ___N Have you ever been pregnant? __Yes __No

ALLERGIES: List ALL allergies (DRUGS AND OTHERS): ____________________________________

____

PATIENT MEDICAL HISTORY

MEDICATIONS:

List ALL medications you are taking with doses (Prescription, over the counter or contraceptive medications.)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Circle if you are taking: Aspirin Plavix (clopidogrel) Coumadin (warfarin)

SOCIAL HISTORY:

Do you use tobacco products? ____Yes ____No If yes, what?_________________ Packs per day?_______

Do you use alcohol? ___Yes ___No What do you drink? _________________ How often? _____________

Are you married?	Yes	No	If yes, for how long?
If not married, do you live alone?	Yes	No	If not, who do you live with?
Did you graduate from high school?	Yes	No	What level of education did you obtain?
Are you employed?	Yes	No	What is your occupation?
Are you retired?	Yes	No	What was your occupation?

FAMILY HISTORY:

Has any member of your family had or do they currently have (check the ones that apply):

___Hepatitis ___Cancer ___Tuberculosis ___Diabetes ___ Kidney Problems ___Other

___Heart Problems ____Asthma ___Lung Problems ___ Epilepsy ___ High Blood Pressure

If a member of your immediate family is deceased, please state the cause of death: ____________________

REVIEW OF SYSTEMS:

Please circle all that apply and explain in space.

General Health:	Exposure to communicable disease, weight loss, fever, etc.	
Eyes:	Glaucoma, cataracts, vision problems, etc.	
Ears/Nose/Mouth/Throat:	Hearing, swallowing problems, etc.	
Cardiovascular:	Heart disease, hypertension, angina, heart attack, pacemaker, etc.	
Respiratory:	Asthma, bronchitis, COPD, tuberculosis, pneumonia, etc.	
Gastrointestinal:	Stomach or colon problems, diarrhea, constipation, ulcers, etc.	
Genitourinary:	Bladder or kidney problems	
Musculoskeletal:	Arthritis, difficulty ambulating, use of cane, walker, w/c, etc.	
Integumentary:	Bruising, swelling, scars, marks, tattoos, skin problems, etc.	
Psychiatric:	Mental or emotional problems, depression, mental illness, etc	
Neurological:	Stroke, epilepsy, seizures, loss of sensation or function, etc.	
Hematologic/Lymphatic:	Unusual bleeding, lumps, masses, liver problems, etc	
Endocrine:	Diabetes, thyroid or hormone problems, etc	
Allergic/Immunologic:	Allergies, problems w/ anesthesia, current immunizations	

The above information is true, correct, and complete to the best of my belief.

Signature ____ **Date** _______________

Sleep Solutions

Patient Name:______________________________ Date:______________

Height:__________ Weight:__________ Date of Birth:________________

Sleep Assessment

Do other people tell you that you snore loudly?	YES	NO
Have you been told that you stop breathing during the night?	YES	NO
Have you been told that your arms/legs jerk during sleep?	YES	NO
Have you ever had a sleep study before?	YES	NO

EPWORTH SLEEPINESS SCALE

In the following situations, how likely would you be to actually doze off? Even if you have not done some of these things recently, try to estimate how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

Situation:

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting inactive in a public place (ie: a theater or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting down and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
Total				

Dr. Shon Cook
Neurosurgery
Pre-Surgery Questionnaire

Name ___________________________ Date of Birth _______________

1. Do you have or have you had any heart problems?

   no   yes   please list: _____________________________________

2. Are you currently or have ever been on any type of blood thinners?

(Asprin, Plavix, Coumadin, Eliquis, Brilinta, etc.)

   no   yes   please list: _____________________________________

3. Have you ever seen a cardiologist?   no   yes

   Doctor's name: ____

   Phone number: __________________   Fax: __________________

4. When was your last EKG?

   Date: ___________ Where: __________________________________

5. Have you ever had an abnormal EKG?

   Date: ___________ Where: __________________________________

Please list below any other pressing health issues that might require a clearance prior to surgery. (Such as: lung/breathing problems or high blood pressure).

____

____

Signature __________________________ Today's Date _______________

Neurosurgery Office Policy

Welcome to the office of Dr. Shon Cook. This letter will provide you with some basic information about our practice and hopefully familiarize you with our office. By signing the bottom, you affirm that you have read and understand these policies. Keep a copy of this form for future reference. It is also available on Dr. Cook's website.

Office hours: Monday- Thursday 8:00 a.m.- 5:00 p.m., Fridays 8:00 am- 4:00 pm, excluding holidays. We close between approx. 12:00 p.m. and 1:00 pm for lunch, depending on clinic needs. After hours, our recording instructs: ***In the event of a medical emergency, please go to the Emergency Room.*** No patient should feel they are overreacting by going to the ER. If you are experiencing a problem that you feel cannot wait until the next business day, it is reasonable and necessary to go to where you can be examined by a doctor.

Coverage after Office Hours: Dr. Cook shares call coverage with Dr. Jeffrey Nees. The physician "on-call" takes over the care of all patients when Dr. Cook is not available, and may round on hospital inpatients during the week in certain circumstances, as no physician is able to be available 24/7.

Appointments: We make every effort to schedule our patients at the earliest opportunity and see them in a timely manner. However, due to the nature of neurosurgical practice, occasionally the doctor is called to a hospital emergency with very little notice, which can cause delays in our schedule. We apologize for any inconvenience and ask for your patience in these instances. **To help us in giving everyone the earliest possible appointment, please give us at least 24 hours notice if you need to cancel or reschedule your appointment so we can offer your time slot to another patient.**

MRI/CT scans/x-rays, etc: **It is very important that you remember to bring your actual films with you to the appointment**. **The physician will not be able to evaluate you without them**. **A typed film report does *not* contain adequate detail to make a surgical decision. It is the patient's responsibility to see that all films are here at the time of the appointment**.

Email and Texts: Please see separate "Unsecured Electronic Communication Policy".

Surgery: Dr. Cook performs surgery at Community Hospital and Saint Anthony Hospital. Each hospital gives excellent care. Except when equipment requirements dictate, the choice of hospital is left entirely up to you. During most spine and some cranial surgeries, Dr. Cook monitors nerves with real time feedback to give the patient the best care and minimize the risk of nerve damage during surgery.

Prescriptions: Surgical practices require the physician to be out of the office most of the time, and charts often need to be reviewed for each medication request. Also, changes in Federal drug laws now require that most pain medicine prescriptions be on a written prescription, signed by the physician only. Physician assistants can no longer prescribe most pain medicine, nor can most pain medicine be called in any more. Due to these factors, we require patients to request their refills at least 72 hours in advance of the need. To make a request, call the prescription line and leave the following information: 1) your name/ birth date; 2) medication; 3) pharmacy phone#; 4) dosage/medication questions. In keeping with Federal and State laws, early refills cannot be authorized.

Payment: Payment is due at the time of service. The payment is determined by the following:

1. Insured by Medicare or a private insurance: Copay is due at time of service. This office accepts cash, check, and major credit cards. Refunds are sent routinely in the event that your copay is overpaid. After your insurance claim has processed, you will be billed for the balance of your portion as detailed on the Explanation of Benefits provided by your insurance company.
2. VERIFIED worker's compensation patients: You must supply our office with your employer's work comp insurance carrier and address, your claim number, the date/time/location of injury, and the name/phone number of adjuster or employer to verify information.

Disability form policy: There will be a $30 charge for each disability or family medical leave form filled out by our office, due when the request is made. Please allow 10-14 days for completion, as medical care always takes precedence over paperwork.

Investment Discolsure: In the interest of quality medical care, Dr. Cook owns a percentage in the following facilities and services: Healthcare Partners Inc. (Community Hospital) and Vantage MRI. He in no way requires any patient to use these facilities. He is also occasionally reimbursed for educational and training services provided to instrument manufacturers. He receives no monetary incentive for using any particular implants. Feel free to discuss your surgical choices with Dr. Cook or any of his office staff.

Patient Signature____ Date__________________________________

NEUROSURGERY TREATMENT AGREEMENT

Contract for Controlled Substance (Narcotic) Prescription

This is an agreement between (patient full name)____ and Shon Cook, MD.

In the event that I am diagnosed with a medical condition, which could require the prescription of narcotic pain medication, I agree with the following guidelines. The goal of medication therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a narcotic increases certain risks, which include but are not limited to:

- Addiction
- Allergic reactions, overdose, and/or fatal complications
- Breathing problems
- Drowsiness, dizziness and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Development of tolerance

I agree with the following guidelines:

1. I will take medication prescribed by Shon Cook, M.D. only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and **early refills will not be allowed for any reason.**

2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will not be allowed to obtain early refills or receive replacement of lost or stolen medication. **Refills will only be provided during office hours, and must be left on the prescription line 72 hours in advance of the need.** Information needed on the Prescription line is: name, medication, dosage, and pharmacy name and phone number.

3. **I will obtain all of my narcotics from only ONE physician and have all prescriptions filled at ONE pharmacy.** I will not accept narcotic medication from any other individual or physician while I am receiving them from Shon Cook, M.D. In the event of an acute emergency and medications are given to me by another physician or emergency room, I will notify Dr. Cook within 72 hours of obtaining them.
The pharmacy I use is: ____

4. I agree to see Shon Cook, MD for ongoing case management and will keep regularly scheduled appointments as long as I am under his care. If I do not keep my appointments, my physician will be unable to provide me with any medication.
5. If my physician believes it is in my best interest, I agree to have a third party, such as a spouse or family member provide my medications to me.
6. **I understand if I do not follow these guidelines, I understand that my narcotic prescriptions and/or my entire treatment with my physician my be stopped. If the violation is serious, it may be reported to my primary physician, local medical facilities, and proper authorities.**

Patient Signature_______________________________________**Date**__________________________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Shon Cook, MD may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations**. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Cook reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Nicole Cook	Shon Cook, MD
Name of Privacy Officer	Practice
10001 S. Western Avenue, Suite 101	Oklahoma City, OK 73139
Address	City, State, Zip

Telephone

With my consent, Shon Cook, MD may call or text my designated phone number and leave a message (on voice mail, text, answering machine, or by person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to y clinical care, including laboratory and other results.

Mail

With my consent, Shon Cook, MD may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, Shon Cook, MD may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Shon Cook, MD restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Shon Cook, MD.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Shon Cook, MD may decline to provide treatment to me.

Print Patient's Name	Signature of Patient **or Legal Guardian*	Date

Attention Privacy Officer:

If a patient wishes to limit, how they are contacted by our practice or the release of their information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.

©

Unsecured Electronic Communication Policy

Shon Cook, MD, PLLC

Dr. Cook answers email from patients almost every night depending on circumstances. Email is a very effective means of direct communication with Dr. Cook. Patients also find it very useful to text pictures of their incisions after surgery if there are any concerns about infection or healing, which often saves themselves hours of unnecessary travel, and other times significantly speeds up the start of appropriate treatment.

However, please note that Federal law now prohibits medical practices from sending you email or texts that are unencrypted, or what they define as "unsecure". Some patients appreciate the tradeoff between security and easy, fast, effective communication. In the interest of facilitating easy communication with you, your initiation of a conversation with our office by normal unencrypted email or text authorizes any member of our office to reply with an unencrypted email or text that may contain confidential medical information about you, only by replying to the address you provide. Please confirm that you understand by signing below:

Signature: ______________________________________ Date: ___________________

In addition, if you would like to allow our office to initiate electronic communication with you via unencrypted or "unsecured" email or text, please confirm below:

I provide consent for the practice to communicate with me by "unsecure" text using the

number(s) ________________________________, _________________________________

Signature: ______________________________________ Date: ___________________

I provide consent for the practice to communicate with me by "unsecure" email using the

addresses(s) ______________________________, _________________________________

Signature: ______________________________________ Date: ___________________

You may change these preferences at any time by reading and filling out this form again.

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 health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your **individually identifiable health information (IIHI)**.
Please review this notice carefully.

A. Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your **individually identifiable health information (IIHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Our obligations concerning the use and disclosure of your IIHI
- Your privacy rights in your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this notice, please contact our privacy officer. The name and contact information of our privacy officer can be obtained from the receptionist at our office.

C. We may use and disclose your individually identifiable health information (IIHI) in the following ways:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

©

D. Use and disclosure of your IIHI in certain special circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. Your rights regarding your IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to our privacy officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our privacy officer. Your request must describe in a clear and concise fashion:
(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our privacy officer in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our privacy officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) not accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operation purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our privacy officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our privacy officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, SW. Washington, D.C. 20201. To file a complaint with our practice, contact our privacy officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer.

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