East Liberty
Family Health Care Center
A CHRISTIAN MINISTRY OF
WHOLE PERSON HEALTH CARE

Patient Registration Form

Patient Information

Please have form of ID ready for reception staff

Last Name:	First Name and Middle Initial:	Date of Birth (MM/DD/YY):	Sex: ☐M ☐F
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email:	SSN: ☐N/A ☐Decline to answer		

Responsible Party : ☐Self
☐Other (if other, complete below)
Name: _______________________ Relation to patient: ________________________
Email: _______________________ Cell Phone: ________________________
DOB: _______________________

Emergency Contact :

Name: ________________________ Relation to patient: ________________________Cell Phone: __________________

Additional Information

PCP (as stated on insurance card):

Marital Status:
☐Divorced ☐Married ☐Partner ☐Single ☐Unknown ☐Widowed ☐ Legally Separated

Language: _______________________________
Do you need an interpreter for your appointments? ☐Yes ☐No

Race:
☐Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐American Indian/Alaskan Native
☐ Black or African American
☐ White
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ More than One Race
☐ Decline to answer
☐ Other: ___________________

Ethnicity *(choose only one)*:
☐Mexican, Mexican American, Chicano/a
☐Puerto Rican
☐Cuban
☐South American
☐Central American
☐Not Hispanic
☐Decline to specify

Pharmacy: ☐ELFHCC Pharmacy – Lincoln/Lemington ☐ ELFHCC Pharmacy – East Liberty ☐ Other (please specify):

Name: ______________________________ Address: ________________________ Telephone: ______________________

PATIENT NAME:

Insurance Information:	
Please have insurance card ready for reception staff	
☐ Commercial ☐ Medicare ☐ Medicaid ☐ Uninsured (ELFHCC will see all patients regardless of their ability to pay)	
Primary Insurance Carrier:	
Member ID:	Co-pay (if listed on card):
Insured's Name:	Patient Relationship to Insured:
Group No:	*Medicare Number (if applicable):*

Secondary Insurance: ☐ Yes ☐ N/A	
☐ Commercial ☐ Medicare ☐ Medicaid ☐ N/A	
Secondary Insurance Carrier:	
Member ID:	Co-pay (if listed on card):
Insured's Name:	Patient Relationship to Insured:
Group No:	*Medicare Number (if applicable):*

Patient Financial Screen	
This information will determine if a sliding fee discount is available for you based solely on your household income and family size. If you qualify, please fill out the Sliding Fee Scale Discount Program application that is attached. Proof of income will be required.	
Approximate Gross Income $: (total for household):	☐ Decline to answer
☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually	
Family Size:	
FOR OFFICE USE ONLY:	
☐ Documentation on Proof of Income ☐ Proof of Income/Unemployment ☐ Picture ID ☐ Proof of Address ☐ Non Proof of Income (The patient will be set to 100% responsibility level)	
Assigned Sliding Fee Schedule / Sliding Scale Type: ☐ L1 ☐ L2 ☐ L3 ☐ L4 ☐ L5 ☐ L6+ or N/A	

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PATIENT NAME:

Additional Information	
Due to federal reporting regulations, the following information is required for all of our patients. All information is confidential and must be collected on an annual basis.	
Are you employed as an agricultural worker?	☐ No ☐ Yes
If yes, please indicate which type of work	☐ Agricultural Seasonal ☐ Agricultural Migrant
Are you a veteran?	☐ No ☐ Yes
Are you currently homeless?	☐ No ☐ Yes
If you answered yes above, please specify your specific homeless status	☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Permanent Supportive Housing ☐ Other ☐ Unknown
Do you currently live in public housing?	☐ No ☐ Yes
Do you have any special communication needs? Visual, hearing, etc.	☐ No ☐ Yes
If yes, please specify	☐ Hearing ☐ Vision ☐ Cognitive
I acknowledge that all immunization records will be transmitted to the Pennsylvania Immunization Electronic Registry System (PIERS). To opt out I can contact the state at: 877-774-4748 or by emailing RA-DHVaxRecords@pa.gov	

Sexual Orientation / Gender Identification (SO/GI)	
Gender Identity: How do you describe yourself? ☐Male ☐Female ☐Female-to-Male (FTM)/Transgender Male/Trans Man ☐Male-to-Female (MTF)/Transgender Female/Trans Woman ☐Genderqueer/Gender Non-Conforming ☐Choose not to disclose ☐Unknown ☐Other:_______________________________	What sex were you assigned at birth on your birth certificate? ☐ Male ☐ Female Sexual Orientation: Do you consider yourself to be: ☐ Lesbian/Gay or Homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose ☐ Something else (Please specify):

Patient Certification:		
I CERTIFY THAT ALL INFORMATION GIVEN BY ME IS TRUE. I UNDERSTAND THAT EAST LIBERTY FAMILY HEALTH CARE CENTER WILL PROVIDE HEALTH CARE UNDER THE MANAGEMENT OF THE MEDICAL, DENTAL AND OTHER ALLIED PROFESSIONALS AND NURSING STAFF ASSISTED BY OTHER EMPLOYEES TO PROVIDE CARE AND TO ADMINISTER SUCH DIAGNOSTIC AND THERAPEUTIC TESTS, PROCEDUREs AND TREATMENTS AS THE JUDGEMENT OF THE LICENSED PROFESSIONAL STAFF, MAY BE DEEMED NECESSARY OR ADVISABLE. EAST LIBERTY FAMILY HEALTH CARE CENTER IS NOT LIABLE FOR ANY ACTS OR OMISSIONS IN FOLLOWING DOCTOR'S ORDERS. I CONSENT TO ANY SERVICES RENDERED TO ME OR MY DEPENDENTS. **I ACCEPT RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT ALL FEES ARE DUE WHEN SERVICES ARE RENDERED.** I AUTHORIZE PAYMENT OF HEALTH CARE BENEFITS TO EAST LIBERTY FAMILY HEALTH CARE CENTER. I ACCEPT RESPONSIBILITY FOR ANY FEES INCURRED IN THE COLLECTION OF THIS ACCOUNT. I AUTHORIZE EAST LIBERTY FAMILY HEALTH CARE CENTER TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THIS OR ANY RELATED CLAIMS. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. A COPY OF THIS RELEASE IS USABLE IN PLACE OF ORIGINAL. **IN THE INTEREST OF MY MEDICAL CARE, I AM RESPONSIBLE TO MAKE SURE MY PROVIDER HAS MY UP-TO-DATE TELEPHONE NUMBER(S) AND ADDRESS. MY PROVIDER MAY HAVE TO REACH ME REGARDING MY HEALTH CARE. BY SIGNING THIS FORM, I GIVE EAST LIBERTY FAMILY HEALTH CARE CENTER CONSENT TO CHECK MY EXTERNAL MEDICATION HISTORY.**		
Name:	Signature:	Date:
Staff Witness:	Signature:	Date:

East Liberty
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WHOLE PERSON HEALTH CARE

Consent to Treatment, Record Release, Payment, and Health Care Operations

Consent to Treatment
By my signature below, I acknowledge that I have requested health care services from the East Liberty Family Health Care Center (ELFHCC). I freely and voluntarily authorize and give my consent to the medical, dental, nursing and other staff ELFHCC to provide to me health care services, administer medication and perform diagnostic and therapeutic tests, procedures and treatments as are indicated for my care.

Records
I give my permission for East Liberty Family Health Care Center (ELFHCC) to release my medical information, including electronic medical records, to my insurance carrier, physicians and other healthcare providers involved in my care and to the organizations in which they practice.

Appointments
I agree to keep scheduled appointments and to follow through on the care plan(s) or agreement(s) I make with the health care provider. Should I be unable to keep an appointment, I agree to notify the Health Center 24 hours in advance to cancel and/or reschedule. I agree to be courteous and respectful to all the staff and providers at East Liberty Family Health Care Center.

Billing
I authorize East Liberty Family Health Care Center (ELFHCC) to bill my insurance carrier and request such payments to be made directly to East Liberty Family Health Care Center. I certify that the information I have given about my insurance coverage or other payment sources is correct. I authorize East Liberty Family Health Care Center to act on my behalf and as my representative to request reconsideration by my managed care plan or utilization review entity for coverage.

Financial Responsibility
In order to provide health care services consistent with the East Liberty Family Health Care Center's mission statement, I understand that the East Liberty Family Health Care Center requires that their patients contribute toward the cost of the health care received, as they are able. In order to fulfill this mission, I understand that East Liberty Family Health Care Center is committed to providing health care services with consideration to their patient's ability to pay and to respect the financial responsibility of all their patients.

I understand that East Liberty Family Health Care Center offers financial counseling services, which includes the sliding fee discount schedule. The sliding discount takes into account family size and income.

Consent to Obtain External Prescription History
I authorize the East Liberty Family Health Care Center and its affiliate provider to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers maybe be viewable by my providers and staff at the East Liberty Family Health Care Center, and it may include prescriptions for several prior years.

MY SIGNATURE BELOW CERTIFIES THAT I
READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS

Privacy Practices
I acknowledge that I have received a copy of the East Liberty Family Health Care Center's Notice of Privacy Practices, which describes how my private health information may be used and disclosed by East Liberty Family Health Care Center, and how I may obtain access to and control the use and disclosure of this information.

I have read this Consent to Treatment, Record Release, Payment, and Health Care Operations and have had any questions answered to my satisfaction.

Signature____Date ________________

If the patient is a minor or has a legal representative, please have parent or representative sign here:

Signature____Date _________________

(Relationship to the patient) ____

ATTACHMENT A

SLIDING FEE DISCOUNT APPLICATION

We are committed to providing quality health services to all of our patients regardless of their ability to pay. This application will determine if a sliding fee discount is available for you based solely on your household income and family size.

Household Income:
Any taxable or non-taxable income that would be reported on a tax return. ***Examples***: Wages, social security benefits, child support, public assistance, alimony, unemployment benefits.
Noncash benefits (such as food stamps and housing subsidies) ***do not*** *count.*

Family Size:
The householder and spouse plus anyone who is typically included as a dependent on a tax return

Household Member Name	**D.O. B**	**Income Amount**	**Frequency** Monthly Bi-Weekly Annually	**Source** (wages, Alimony, etc.)
		TOTAL		

________I understand that ELFHCC healthcare services will be covered under the SFDP.

________I understand that I am responsible for any outside lab or major dental work charges.

________I understand that failure on my part to submit proof of income will result in denial of my sliding fee discount.

I certify that the family size and income information shown above is correct. I understand that I am responsible for submitting proof of income before any discounts can be approved and continued.

______________________ ______________________ ____________
Signature Printed Name Date

ATTACHMENT B

AFFIDAVIT

I am providing this affidavit to verify my income, as I have no other income documentation available to me.

(Yo estoy haciendo este documento oficial para verificar, como no tengo otra documentación disponible.)

I declare that our income is from: *(Yo declare que nuestros ingresos son de*):

Family Member Name Who Receives Income (nombre del miembro de familia quien recibe ingreso	Source of Income (Fuente de ingreso)	Amount Received (Cantidad recibido)	How Often Received (Cuanta frequencia recibido)	Total for Year *(Total del año)*

I certify that our family will recieve a total yearly income of: $_________________.

(*Yo certifico que nuestra familia recibirá un ingreso total del año de*) $_________________

I understand that this information is subject to verification by the state of Pennsylvania. I certify that the information presented in this letter is true and correct to the best of my knowledge and belief.

(Yo entiendo que esta información esta sujeto al verificación por el estado de Pensilvania. Yo certifico que la información presentada en esta carta esta verdadera y correcta a lo mejor de mi conocimiento y creencia.)

Signed (Firmado),

Name (*Nombre completo*) ____

Signature (*Firma*) ____

Date (*Fecha*) ______________________________

Attachment B
(Affidavit – English & Spanish) Rev. 2024

ATTACHMENT C

PUBLIC NOTICE SIGNAGE

Sample Discount Fee Policy Signs

NOTICE TO PATIENTS

This practice serves all patients regardless of ability to pay
Discounts for essential services are offered depending upon family size and income You may apply for a discount at the front desk

*** * ***

AVISO PARA PACIENTES

Los centros de salud ofrecen servicios de atención médica primaria y preventiva, sin considerar la capacidad de los pacientes para pagar.
Los cargos generados por servicios de salud son calculados de acuerdo al nivel de ingreso del paciente.
Pacientes pueden aplicar para servicios médicos con la recepcionista en la clínica.

Attachment C
(Notice Cont'd – English & Spanish – Rev. 2024)

ATTACHMENT C (cont'd)

NOTICE
This Practice has Adopted the Following Policies for Charges for Health Care Services

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at no charge, or at a reduced charge, to persons unable to pay for services. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of his/her inability to pay for services, or because payment for the health services will be made under Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

We will accept assignment under the Social Security Act for all services for which payment may be made under Part B of Title XVIII ("Medicare") of the Act.

We have an agreement with the State agency which administers the State plan for medical assistance under Title XIX ("Medicaid") of the Social Security Act to provide services to persons entitled to medical assistance under the plan.

AVISO
La clínica ha adoptado las siguientes pólizas relacionadas con costos por servicios de salud

Aplicaremos costos por servicios de salud a las personas basado en la tasa promedio. El servicio de salud proporcionara atención sin costos, o con costos reducidos, a personas imposibilitadas de pagar. Habrá un recargo por servicios proporcionados a pagar de acuerdo a la capacidad del paciente o a pagar por un tercero autorizado o bajo obligación legal por el pago de los costos.

No se privará servicios médicos a las personas debido a la incapacidad del pago por éstos, o porque el pago de las prestaciones que se otorgaron bajo el Titulo XVIII ("Medicare") Parte A y B o por el Título XIX ("Medicaid") del Acta del Seguro Social.

Aceptaremos solicitudes bajo el Acta del Seguro Social por todas las prestaciones que se pagarán bajo Parte B del Título XVIII ("Medicare") del Acta.

Tenemos un convenio con la agencia del estado que administra el plan de asistencia médica del Estado bajo el Título XIX ("Medicaid") del Acta del Seguro Social para proporcionar servicios a personas que califican bajo el plan de asistencia médica.

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AUTHORIZATION FOR PROXY ACCESS

Patient Information

First Name: ______________________________ Last Name: ___________________________

DOB: _________________________

Street Address: __________________________________

City: __________________________________ State: __________ Zip: __________

Phone Number: _________________

Type of Proxy Access (13 to 17 years old) (PLEASE INITIAL)

Full _____ (access to all health information on the patient portal)

Type of Proxy Access (18 years and older) (PLEASE INITIAL)

Full _____ (*access to all health information on the patient portal)*

Partial ____ (access to specific health information on the patient portal – on back of form)

Proxy Information

First Name: ______________________________ Last Name: ___________________________

DOB: _________________________

Street Address: __________________________________

City: __________________________________ State: __________ Zip: __________

Phone Number: _________________ Email Address: ______________________________

Proxy Relationship to Patient

Parent:_________

Court Appointed Legal Guardian:_________

Spouse: ___________

If Other, Please Specify ____

I have read, understand and agree to allow proxy access to my patient portal at East Liberty Family Health Care Center to the individual listed above as indicated. I also hereby affirm that I am the patient identified above and all information I provided is correct. I understand and agree that by granting this access, my proxy will have access to my protected health information.

Patient Signature: ____ Date: ____________

Witness Signature: ____ Date: ____________

Partial Proxy Access Includes:

- Landing Homepage
- Demographics; Update Street Address; Pharmacy
- Information Section of Patient Demographics
- Current Statement displays
- View Past Statements
- Dental Treatment Plans
- Directions to Locations
- View Hours Locations are Open
- List of Providers
- Vitals in Progress Notes (for patients under 18 years of age)
- Previous Immunizations
- Request Historical Immunizations State Form
- Televisit Compatibility Test, Televisit FAQs
- Policies ELFHCC Posts to Portal

East Liberty
Family Health Care Center
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WHOLE PERSON HEALTH CARE

East Liberty Family Health Care Center

Parent/Legal Guardian Information for Minor Children

(complete one form per child)

Name of Minor: ___________________________________

Date of Birth: ___________________________________

Address: ___________________________________

Parent/Legal Guardian	Parent/Legal Guardian
Name:	Name:
DOB:	DOB:
Address same as patient (circle one) *Yes No* If no, enter address below	Address same as patient (circle one) *Yes No* If no, enter address below
Address:	Address:
City:	City:
State:	State:
Zip Code:	Zip Code:
Phone Number:	Phone Number:

I, ____, am the Parent/Legal Guardian (if Legal Guardian, attach copy of court order) of the minor child listed above. There are no court orders now in effect that would prohibit the parents/legal guardians listed above from consenting to medical/dental treatment for the above minor child or appointing a personal representative for the child. It is the parents/legal guardians responsibly to notify East Liberty Family Health Care Center, if the above information changes.

____ ____________________

Signature of Parent/Legal Guardian Date

EAST LIBERTY FAMILY HEALTH CARE CENTER
PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Patient Name: ____ Date of Birth: __________________

Patient Address: ____

Telephone: ____ Social Security No: ________________

Purpose of request:

I authorize the following:

East Liberty Family Health Care Center
7157 Mary Peck Bond Place
Attn: Medical Records
Pittsburgh, PA 15206
Phone: 412-661-2802
Fax: 412- 661-8020

to disclose or provide my/my child's protected health information to the following individual who is authorized to act as my/my child's personal representative for the purposes of receiving protected health information about myself/my child. As my/my child's personal representative, he/she can (initial all that apply):

____ Make appointments for health care services
____ Have discussions with health care providers about routine tests and treatments (that do not require informed consent)
____ Access medical information, as necessary, to have discussions with health care providers about routine tests and treatment.
____ Discuss billing and insurance concerns.

As the personal representative for a minor child, he/she can (initial all that apply):

____ Accompany my minor child to East Liberty Family Health Care Center for appointments.
____ Make decisions of a routine nature as determined by the discretion of East Liberty Family Health Care Center health care provider serving my child during an appointment.

Note: **This form is not applicable and cannot be used to disclose behavioral health treatment, drug/alcohol treatment, and communicable diseases information or when major health care decisions are involved.**

____ ____________________________________
Name of Patient's Personal Representative Personal Representative Phone Number

____
Personal Representative Address

Expiration or termination of authorization: This Authorization will remain in effect until terminated by you or if the patient is a minor, when the patient turns 18 years of age.

EAST LIBERTY FAMILY HEALTH CARE CENTER
PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Right to Revoke or terminate: You have the right to revoke or terminate this authorization by submitting a written request. Please contact the East Liberty Family Health Care Center Medical Record Department at the above listed phone number for instructions on revoking this authorization.

Redisclosure: East Liberty Family Health Care Center has no control over the individual(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

____ ____________________
Patient Signature Date

____ ____________________
Signature of Legal Guardian/Legal Representative Date

____
Printed Name of Legal Guardian/Legal Representative

Basis of Authority of Legal Guardian/Legal Representative
If you are the Legal Guardian/Legal Representative who provided written authorization, please check the basis for the authority.

__ Parent of Minor
__ Power of Attorney (copy attached)
___ Guardianship Order (copy attached)
___ Other, please specify_____________

REVOCATION OF PERSONAL REPRESENTATIVE

I, ____, hereby revoke the authorization for
Printed Name of Patient/Legal Guardian/Legal Representative

personal representative, I provided to East Liberty Family Health Care Center, which I signed

on________________ appointing ____. I
Date *Name of Appointed Personal Representative*

understand that this revocation does not apply to any action that East Liberty Family Health Care Center has taken in reliance on the authorization that I have signed earlier.

____ ____________________
Patient Signature Date

____ ____________________
Signature of Legal Guardian/Legal Representative Date

____
Printed Name of Legal Guardian/Legal Representative

East Liberty Office
6023 Harvard Street
Pittsburgh, PA 15206
412-661-2802
Fax 412-661-8020

Lincoln-Lemington Office
7157 Mary Peck Bond Pl.
Pittsburgh, PA 15206
412-661-2802
Fax 412-661-8020

Authorization for Release of Medical and/or Dental Records

I authorize the release of my health information, **as described below**

TO:

Provider/Facility East Liberty Family Health Care Center

Address 7157 Mary Peck Bond Place

City Pittsburgh State PA Zip 15206

Telephone 412-661-2802 **Fax**: 412-661-8020

FROM:

Provider/Facility: ____________________

Address: ____________________

City: __________ **State**: __________ **Zip**: __________

Telephone: __________ **Fax**: __________

Patient Name: ____________________ Date of Birth: ____________________

Patient Address: ____________________

Telephone: ____________________ Social Security No.: ____________________

INFORMATION TO BE DISCLOSED:

___ Medical Record ___ Dental Record ___ Other (please specify)____________________

Covering the period(s) of healthcare: From: __________(date)** To: __________(date)**

If dates are not provided, healthcare records will be provided for three (3) years prior to the date of the request.

FOR THE PURPOSE OF: (CHECK ALL THAT APPLY):

___ Continuing Care ___ Benefits and payment determination ___ Personal Use ___ Legal Reasons

___ Other (Please specify) ____________________

I understand that my records may contain sensitive and private health information.

In a primary care setting, reference to infectious disease, drug and alcohol use, and mental health may be part of general documents (such as, but not limited to: History and Physical, Progress notes), which will be released.

Separate documents, pertaining to internal or external specialists' care, regarding the following, **WILL NOT BE RELEASED** unless I, or my legal representative, authorize it, as checked below:

___ HIV _____ Drug/Alcohol _________ Mental Health/Psychiatric Care

I understand that:

- The records released under this authorization may possibly be re-disclosed by the facility that receives them and that, therefore, if the East Liberty Family Health Care Center is releasing records, 1) this office is neither responsible nor liable as a result of such re-disclosure and 2) that such information would no longer be protected by the Privacy Rule.
- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- My decision to revoke this authorization does not apply to any release of my records that may have occurred prior to such date of revocation.
- Unless otherwise revoked, this authorization will expire in ninety (90} days.
- I am entitled to a copy of this completed form.
- I will not be denied treatment by the East Liberty Family Health Care Center if I refuse to sign this form.

____________________ ____________________

Signature of Patient or Legal Representative Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

____________________ ____________________

Signature of Witness Date

Office use only: _____Patient received copy of release form _____Patient refused copy of release form

Date Reviewed: __________

Rev. 3/2017 ELFHCC 12002a

EAST LIBERTY FAMILY HEALTH CARE CENTER

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to maintain the confidentiality of your PHI, and to follow specific rules when using and disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using and disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow by law the terms of this Notice. We reserve the right to change the terms of our Notice, and make the new notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment, The Notice will also be posted in a conspicuous location in the practice, and if such is maintained the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure In writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health records, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy In electronic format. We have the right to charge a reasonable, cost based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information* - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

*If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Officer. Contact information is provided on the following page.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care, or to provide Information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to apt out of receiving further fundraising communication. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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 PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, (e.g., In a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object for the following purposes: If required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.): with respect to a group health plan, to disclosed information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Officer at: 412-661-2802.

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