ADVANCED CARDIOVASCULAR & VEIN CENTER, P. C.

1340 Union University Dr. Jackson, Tennessee 38305

Alex Alperovich, M.D., F.A.C.C., F.S.C.A.I.

Information Sheet

Date: _____

Name: _____
(Last) (First) (M.I.)

Address: _____
(Number & Street) (City) (State) (Zip Code)

Telephone: _____
(Home) (Mobile)

Consent to Text?: Yes_____No_____**SS#:** _____

Email Address: _____

Age: _____ **Date of Birth:** _____ **Gender:** M F **Race:** _____

Last Grade Completed in School: 1 2 3 4 5 6 7 8 9 10 11 12 **College**: _____

Name of Spouse: _____ **Marital Status:** _____

Nearest Relative: _____

Relationship: _____ **Telephone:** _____

In Case Of Emergency: _____
(Name) (Phone)

Your Referring Physician: _____

Your Employer: _____
(Name) (Phone)

Spouse's Employer: _____
(Name) (Phone)

Bring your insurance card with you and we will make a copy for your chart

ADVANCED
CARDIOVASCULAR & VEIN CENTER

ALEX ALPEROVICH, M.D.
F.A.C.C. F.S.C.A.
Board Certified in Internal Medicine, Cardiology, Interventional Cardiology
Fellow Diplomate of the American Board of Phlebology

Notice of Privacy Practice

We keep a record if the health care services we provide you. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to do so. You may get more information by contacting our Medical Records Department.

X SIGNATURE_____ Date_____

AUTHORIZE TO SHARE HEALTHCARE INFORMATION I permit you to share my healthcare information with :

Name:_____ Phone #:_____ Relationship: _____

Name:_____ Phone #:_____ Relationship: _____

Name:_____ Phone #:_____ Relationship: _____

This authorization ends only upon my written request.

X SIGNATURE: _____ Date: _____

Financial Policy:

Our office is committed to providing quality and cost effective healthcare to our patients. It is essential that you understand what services are covered by your insurance plan and obtain all authorizations prior to your appointment. Your doctor may recommend services he/she feels are beneficial but may not be covered by your insurance. It is your responsibility to understand the limit and restrictions affecting coverage for these services. **If your insurance company requires you to use a specific lab, it is your responsibility to notify us of this.** Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we file all claims for you. **We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all co pays, deductibles, co insurance amounts along with the entire amount of any non-covered services.** Payment for these services will be expected at the time of service. Patients who do not have insurance coverage or proof of coverage or who choose to pay for non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office **prior** to receiving services.

X SIGNATURE: _____ Date: _____

Insurance/Billing Information:

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance to be paid directly to my physician. I authorize my physicial to release any information required to obtain reimbursement. I agree that I am financially responsible for all service provided and should it be necessary to refer the account to a collection business associate. I will be responbsible for all fees including but not limited to collection costs, fees and court costs involved with my account.

X SIGNATURE: _____ Date: _____

No Show Policy: (eff: 1-1-2016)

I am aware that if I fail to appear for scheduled appointments (and fail to cancel appointments) I will be assessed a $30 fee for which I will be responsible for paying prior to scheduling another appointment. Advanced Cardiovascular and Vein Center hopes that this policy, in addition to the reminder service in place, will help to encourage our patients to cancel or reschedule any appointments they are unable to keep.

X SIGNATURE: _____ Date: _____

Today's Date: Patient Name:_____

Date of Birth_____

ACVC *Vein Health History Form*

Does anyone in your family have, or had in the past, varicose veins, leg ulcers or swollen legs? Please indicate by marking "Y" or "N":

Father Y__ N__ Mother Y__ N__ Brother(s) Y__ N__ Sister(s) Y__ N__

Do you experience any of the following in your legs:

Aching: Y__ N__ Pain: Y__ N__ Heaviness: Y__ N__ Fatigue: Y__ N__

Itching/Burning: Y__ N__ Tiredness: Y__ N__ Swollen Ankles: Y__ N__

Restless Legs: Y__ N__ Throbbing: Y__ N__ Leg Cramps: Y__ N__

Other: Y__ N__ (If "Y", please explain in the space below)

Have your veins gotten worse in recent months? Y__ N__ (If "Y", please explain below)

Do you take any medication for pain? (i.e., Motrin, Advil) Y__ N__
If yes, what medication do you take and how many mgs/times per day?

Do you elevate your legs to relieve discomfort? Y__ N__
Do you exercise? Y__ N__ If yes, what kind of exercise and how often?

Do you wear prescription compression stockings? Y__ N__
If yes, what type and gradient? How long have you worn them?
What is the Physician's name who prescribed your compression stockings and when were they prescribed?
Do you wear light support hose (i.e., Sheer Energy)? Y__ N__
If yes, do they provide relief? Y__ N__

What type of work do you do?
How long do you stand (hours per day) at work? At home?
Describe how your symptoms are interfering with your essential job function of your specific occupation:
Which activities?

Have you ever had any test(s) done on your veins? Y__ N__
If yes, when and what type of test and where on the leg?
Were you diagnosed with saphenous vein reflux? Y__ N__
Name of referring Physician and how long you have been under his/her care for treatment of this condition?

Patient Name:_____

ACVC *Vein Health History Form Cont.*

In your own words, please describe the problem for which you are seeking our services:

May we send a report of our findings, recommendations findings to your family doctor? Y__ N__

If so, please give us the name and phone number of your family doctor:_____

Please list all medications that you take at least three times per week:

Are you allergic to anything? Y__ N__
If yes, please list any and all allergies:

Family History: Please indicate if any of the following conditions were present in your immediate family members:

Varicose Veins?	Y__ N__	Phlebitis?	Y__ N__
Venous Ulcers?	Y__ N__	A history of Vein Surgery?	Y__ N__
Deep Vein Thrombosis?	Y__ N__	Blood Clots?	Y__ N__

Past Surgical History:
Have you ever had surgery? Y__ N__
If you have had surgery, what type and when?

Additional Medical History Not Mentioned Above:
Are you presently seeing another physician for anything NOT mentioned above? Y__ N__
If so, What is the Doctor's Name?_____
If so, For what condition(s) is he or she treating you?

Have you ever been hospitalized for anything NOT mentioned above? Y__ N__
If so, for what, at what Hospital, and when?

Have you ever had an injury to either or your legs that required an operation or casting? If so, when? Y__ N__

Patient Name:_____

ACVC *Vein Health History Form (cont.)*

Have you ever had a deep vein thrombosis (D.V.T.) or a blood clot in your leg? Y__ N__
If so, when?
Have you ever had Phlebitis? Y__ N__
If so, when?
Have you ever had a Venous Stasis Ulcer? Y__ N__
If so, when?
Have you ever had a hemorrhage from a Varicose Vein? Y__ N__
If so, when?
Have you ever had Sclerotherapy? Y__ N__
If so, when?
Have you ever had a vein stripping? Y__ N__
If so, when?

Please answer the following very carefully, as it will help your insurance company decide if your vein problems are a covered benefit. In the last six months have you:
Tried support stockings to relieve your vein problems without success? Y__ N__
Had to take time off work because of your vein problems? Y__ N__
Had to take pain medicine because of your vein problems? Y__ N__
Had to limit your activities and lifestyle because of your vein problems? Y__ N__

Please indicate if you have any of the following conditions by marking Y or N:

Diabetes	Y__ N__	Seizures	Y__ N__
Heart Disease	Y__ N__	Renal Failure	Y__ N__
Lung Disease	Y__ N__	Hepatitis	Y__ N__
Hypertension	Y__ N__	HIV infection	Y__ N__
Arthritis	Y__ N__	Fainting	Y__ N__
Cancer	Y__ N__	Tobacco Use	Y__ N__

Please indicate (by marking Y or N) if you currently (or recently) were on any of the following:

Coumadin	Y__ N__	Topical skin medications	Y__ N__
Plavix	Y__ N__	Antibiotics	Y__ N__
Daily Aspirin	Y__ N__	Steroids	Y__ N__

For Women Only: Please indicate by marking Y or N if you are :

Pregnant or think you might be? Y__ N__

Currently Nursing (breast feeding) Y__ N__

Do you think you will have more children? Y__ N__

How many times have you gone through childbirth?

Patient Name:_____

ACVC *Vein Health History Form (cont.)*

Are you taking Oral Contraceptives? Y__ N__

Are you taking Hormone Replacement Therapy? Y__ N__

Do you anticipate starting Hormone Replacement Therapy soon? Y__ N__

Review of Systems: Do you currently have any of the following?
If you mark "Y", please explain in the space below the question

Constitutional: (Fever, chills, recent unexplained loss of appetite or weight). Y__ N__

Eyes: (Any recent unexplained change n visual acuity, double vision, excessive tearing or crusting). Y__ N__

ENT: (No recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears). Y__ N__

Cardiac: (No chest pain, shortness of breath, waking from sleep breathless, or cardiac meds). Y__ N__

Respiratory: (No shortness of breath, productive cough, coughing up blood, or pain with breathing). Y__ N__

Gastrointestinal: (No change in bowel habits, no black, red or bloody stools, vomiting or belly pain). Y__ N__

Musculoskeletal: (No change in walking ability or strength. No painful joints). Y__ N__

Skin: (No problematic rashes or itching, no changes in skin color or sores that won't heal). Y__ N__

Neurological: (No unexpected, unexplained numbness, tingling, or loss of memory or movement). Y__ N__

Psychiatric: (No suicidal thoughts or hallucinations). Y__ N__

NAME: DOB:

MEDICATION LIST

MEDICATION	DOSAGE	FREQUENCY

NAME: DOB:

ALLERGY LIST

ALLERGIES

ALLERGY	REACTION

PREVIOUS CHOLESTEROL MEDICATIONS

MEDICATION	REACTION

Authorization to Release
Medical Information – Treatment Instructions – Prescriptions

Your name: _____ DOB: _____

Insurance Co: _____ Pharmacy name & phone: _____

In order for us to contact you, please indicate all contact telephone numbers and circle your order of preference. We recommend allowing us to leave a message with one of your contact numbers. Please do not list a pager number.

Your home phone: _____ 1 2 3 4 May we leave a message? Yes No

Your work phone: _____ 1 2 3 4 May we leave a message? Yes No

Your cell phone: _____ 1 2 3 4 May we leave a message? Yes No

Alternate phone: _____ 1 2 3 4 May we leave a message? Yes No

Who may we release information to?

Name	Relationship
_____	_____
_____	_____
_____	_____

I give my permission to Dr. Alexander Alperovich and staff of Advanced Cardiovascular and Vein Center to render medical care and treatment. I authorize the physician or their staff to release information pertaining to my care to the above phone numbers, pharmacy, reference laboratories and consulting physicians. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. NO INFORMATION CAN BE RELEASED AFTER CONSENT HAS BEEN WITHDRAWN.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Advanced Cardiovascular & Vein Center's Notice of Privacy Practices as required by HIPPA Privacy Regulations developed Oct.,2002.

Signature: _____ Date: _____

ADVANCED CARDIOVASCULAR & VEIN CENTER, P. C.

172 University Parkway, Suite A Jackson, Tennessee 38305
Alex Alperovich, M.D., F.A.C.C., F.S.C.A.I.

Policy for Completion of Disability/FMLA Forms

If you are having a procedure, you may have a disability policy to compensate you for the time you are anticipated to miss from work. Individuals related to the patient may also access benefits under the Family Medical Leave Act. In order to expedite any related requests, we will require the following:

1. The patient must sign the HIPAA release below.
2. If different from the patient, the individual requesting FMLA benefits must also sign a release of information.
3. A **$10.00** fee must be paid **PRIOR** to our completing this paperwork. ***This fee recurs every time we are required to verify an additional set of paperwork.***
4. Disability requests **will not** be completed until a procedure is performed. The form may be brought into the office or faxed to (731)215-1087 after the procedure has been completed.
5. All personal information is to be filled out in its entirety by the patient or family member prior to submission for completion.
6. In the event subsequent disability forms require completion, the entire process repeats, however the signed authorization can be reused provided the dates of authorization cover the scope of the disability period.
7. Please allow **10 business days** for completion of all forms and provide specific instructions for distribution of the forms, i.e. mailing address, fax numbers.

Authorization for Advanced Cardiovascular & Vein Center, P.C.

Patient Name: _____ Date of Birth: _____

I. My Authorization

You may disclose my health information to: FMLA/Disability Company/H.R. for my employer

II. My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive a health care when the purpose is to create health information for a third party. I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name Relationship

Advanced Cardiovascular & Vein Center, P.C.
1340 Union University Drive
Jackson, Tennessee 38305
Phone: 731-215-1281 Fax: 731-215-1248

I hereby authorize the release , use, and/or disclosure of my medical records as listed below. I understand that the information enclosed in my records may be subject to re disclosure by the recipient and no longer protected by federal privacy regulations.

Patient's Name:_____

Address:_____

Social Security#:_____Date of Birth_____

I authorize Advanced Cardiovascular & Vein Center, P.C. to:

___release my medical records to:_____

___request/obtain my medical records from:_____

Purpose of request/use:___Patient Request ___Continuation of Care

___Other:_____

From 2009 to Present:

- Office based procedures reports (e.g. Stress tests, echo-cardiograms, holter monitor, ultrasound, etc.).

- Lab Work (Berkeley and Chemistry only) (including lipids)

- EKG (last available date)

- Last office note available

- Last summary report for pacemaker or AICD as compiled by the company representative.

I understand that the release of my personal medical records may include information concerning my diagnosis and/or treatment for any of the following: drug/alcohol abuse, psychiatric or mental illness, sexually transmitted diseases which include Human Immunodeficiency Virus (HIV) and/or AIDS virus. This authorization will expire 12 months (1 year) from the date provided at the end of the form.
I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of Healthcare with 2 exceptions:

1. Refusal to sign this form, if it is for disclosure of information created for research that includes treatment, may result in the doctor declining to provide the research related treatment.
2. Refusal to sign this form, if it for disclosure of information created for the sole purpose of creating protected health information for disclosure to third party.

I understand that I may revoke this authorization at anytime by notifying the doctor in writing. The revocation will only be effective from the date received and it will not apply retroactively.
I understand that this authorization will expire on ___/___/____.

_____ _____
Patient's or Responsible party's Signature Date

_____
Printed Patient Name

Advanced Cardiovascular & Vein Center, P.C.
172 W University Parkway, Suite A Jackson, TN 38305

Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

_____ **please initial**

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

_____ **please initial**

Payment for Services

Payment for services, including insurance, co-payment, or self-pay balance amount, is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager. We accept exact cash, checks, MasterCard and Visa . Our failure to collect these amounts may be a violation of our contract with your insurance company. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to your employer and/or insurance company representative.

_____ **please initial**

Returned checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised maybe subject to external collection and additional collection fees, including attorney and other court fees.

_____ please initial

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. Thank you.

My signature below constitutes acknowledgement and acceptance of this policy.

Patient name – Printed:_____

Patient or guardian signature: _____

Date: _____

Advanced Cardiovascular & Vein Center, P.C.
Alex Alperovich, M.D. F.A.C.C., F.S.C.A.I.

APPOINTMENT CANCELLATION/ NO SHOW POLICY

Advanced Cardiovascular and Vein Center is privileged to provide medical and surgical treatment for our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelling appointments without adequate notice. We respectfully request your understanding and agreement to our policy as it is stated below.

NEW PATIENTS

We will give you a reminder call 24 hour in advance of your scheduled appointment. Any new patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours prior to their appointment will be required to pay a fee of $40.00 in order to schedule a new office visit. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will have to be paid prior to your next appointment.

ESTABLISHED PATIENTS/ ULTRASOUND (Patients who have previously seen a physician in our practice)

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours in advance of their appointment will be charged a fee of $30.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday.

If an established patient fails to keep three appointments, or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

Vein Procedure

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 48 hours in advance of their appointment will be charged a fee of $100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday.

FEES

All fees charged by Advanced Cardiovascular & Vein Center pursuant to this No Show/Cancellation policy are not payable by your insurance company.

All fees are payable on or before your next office visit with Advanced Cardiovascular & Vein Center physician or Ultrasound Tech or within 30 days of receipt of a billing statement from Advanced Cardiovascular & Vein Center for that fee, whichever is earlier. Your physician may waive your "no show" fee for good cause shown. To request that this fee be waived, you must email a written request and explanation to the following address: acvcenter@gmail.com . Please enter your Advanced Cardiovascular & Vein Center doctor's name in the subject line of the email. If you do not have access to a computer, you may write a letter to Advanced Cardiovascular & Vein Center appeals, 172 W. University Pkwy Ste A, Jackson, TN 38305. Attention: Clinical Director.

Please remember that it is your responsibility to make certain that we have updated, accurate phone numbers so that we may contact you.

Thank you for your consideration and understanding of our policy.

Patient Signature: _____ Date_____

ADVANCED CARDIOVASCULAR & VEIN CENTER, P. C.

172 University Parkway, Suite A Jackson, Tennessee 38305

Alex Alperovich, M.D., F.A.C.C., F.S.C.A.I.

NOTICE OF PRIVACY PRACTICES

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

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 PROTECTED HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information. 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 protected health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

The terms of this notice apply to all records containing your protected health information 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. You may request a copy of our most current Notice at any time.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use of disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety or the o health and safety of another individual or the public. We will only makes disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. Or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's compensation and similar programs.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health that we may 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 at work. In order to request a type of confidential communication, you must make a written request (using the form we provide to upon request) to the address at the end of this notice specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests.

1. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information 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. The request must be in writing.
2. **Inspection and Copies.** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychosocial records. You must submit your request **in writing**(using the form we provide to you upon request) to the address at the end of this Notice in order to inspect and/or obtain a copy of your health information. Our practice will charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
3. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing (using the form we provide to you upon request). You must provide us with a reason that supports your request for amendment.
4. 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 you for non- treatment or operations purposes. In order to obtain an accounting of disclosures, you must submit your request in writing (using the form we provide to upon request). 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.
5. 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 copy of this notice, contact us at the address below.
6. 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. All complaints must be submitted **in writing**. Send to the address at the end of this Notice. 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.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: