First Time Arrival Checklist

Items to bring:

- Registration Form completed
- Consent to Treat/Acknowledgement of Financial Responsibility/Notice of Privacy Practices Acknowledgement Form Signed
- Medical History Form completed
- Vascular/Neurological Screening Form completed if one of the following applies:
  - Diabetes
  - Over 65, (50 with diabetes)
  - Smoke
  - History of known heart disease
- Personal Representative Authorization Form completed (optional – see form for details)
- All insurance cards and an identification card with a your photo
- Up-to-date list of all medications

After arrival:

We are required to have you sign an acknowledgement that you have received the Notice of Privacy Practices that was included with this packet.

Welcome to Centers For Foot & Ankle Care!

Our Mission: The podiatrists at Centers For Foot & Ankle Care are dedicated to providing you the highest quality foot care. Our practice includes doctors, medical assistants and receptionists who share a commitment to providing the best possible care for you or members of your family.

Complete Foot & Ankle Care: Centers For Foot & Ankle Care specialize in the treatment of any foot or ankle related pain, sports injuries, diseases or other problems. The most common conditions we see include heel and arch pain; diabetic foot care; ingrown and fungal nails; fractures and sprains; corns and calluses; bunions; hammertoes; endoscopic surgery for heel spurs and pinched nerves; reconstructive foot and ankle surgery; and ankle arthroscopy. In addition, we provide pediatric medical and pediatric surgical care.

Scheduling Appointments: When you need an appointment, we ask that you call our office directly. Our receptionist will take your basic information and will ask you the reason for your visit. This is important information so that we can schedule enough time for your appointment with the doctor. Our office hours are generally 9 a.m. to 5 p.m., Monday through Friday with occasional Saturdays and extended hours at certain locations.

Registration: Each time you arrive for your appointment, you will be asked to present your insurance card and verify your address and phone number. While this may seem like an inconvenience, we've found that often the insurance companies make slight changes to the coverage that are important for us to know. Please be prepared to present this information to the receptionist upon checking in for your appointment. Our goal is to have you in the exam room and prepared to see the doctor at your scheduled appointment time. If there are changes in your address, phone number or insurance information, please plan to arrive 10 minutes prior to your scheduled appointment to complete the needed paperwork.

Referrals: If your health plan requires referrals, please be sure that your primary care physician has completed this process before your visit. If this process has not been completed and approved by your insurance company, you may be subject to the entire cost for the visit.

Payment Policy: Centers For Foot & Ankle Care, along with your insurance company, requires that any insurance copayments you may have be made at the time of service. We will collect these copayments after your appointment. Any unapplied payment deposits previously collected may be applied to any outstanding balance according to your insurance policy requirements. If your copayment is not paid at the time of service, CFAC reserves the right to assess a $20.00 fee to the patient's account. For your convenience, we accept cash payments, personal checks, Visa and MasterCard.

Returned Check Reprocessing Charge: Centers For Foot & Ankle Care will assess a $20.00 Returned Check Reprocessing Fee for each check returned unpaid by our bank.

After Hours Protocol: In the event that you need care after hours or on weekends, Centers For Foot & Ankle Care has staff available. Please phone the office and listen for information on having the on-call physician or other staff paged.

Treatment of Minors Policy: Patients under the age of 18 must have a parent/legal guardian present to complete initial paperwork and treatment consent. All minors must have written parental consent with each subsequent office visit, even if they are accompanied by an older sibling, babysitter or grandparent. Without parental consent, the child's appointment will have to be rescheduled. A parent/legal guardian must be present when routine care/injections are administered.

Medication Refill Policy: As part of your medical treatment, our physicians may prescribe medications to be filled by your pharmacy. If you are on regular medications, you may need to have the prescription refilled. Be sure to call our office well in advance of the time your refill is needed.

Follow-up appointments to monitor your progress on medication are very important. When our physicians see you in the office, they will write your prescription with a certain number of refills. If you are due to come into the office for follow-up care, we may not accommodate your request to phone your refill into your pharmacy.

When you come to our office for your visit, be sure to bring an up-to-date list of all medications you are currently taking.

Missed Appointment Policy: We realize that circumstances may cause you to arrive late or miss an appointment. CFAC asks that you call the office at least 24 hours in advance in cases where you know that you are unable to keep your appointment. If you know you will be late, please call us at least 30 minutes in advance.

If you arrive 15 minutes late or more without advance notice, you may be asked to reschedule. If you miss an appointment without giving us advance notice, CFAC reserves the right to charge $20.00 for the missed appointment time. A pattern of missed appointments may result in your dismissal from Centers For Foot & Ankle Care

Billing Office: If you have questions or concerns about your bill or need to set up payment arrangements, please feel free to contact our billing office directly at **513-619-6800.**

Release/Transfer of Medical Records:
CFAC requires an administrative fee for the retrieval, duplication and transfer of a patient's medical chart. This fee covers the cost of the duplication and any applicable postage to forward those medical records. Prior authorization from the patient is required before any copies are released. CFAC's fee policy for the transfer of records is in accordance with Ohio Revised Code 3701.741, with the maximum charge as follows:

- Pages 1-10: $2.92 per page
- Pages 11-50: $0.61 per page
- Pages 50+: $0.25 per page
- ***Only the last two years of the record will be copied.***

After receiving your authorization for release/transfer of records you will be sent a letter stating the cost for the transfer. Upon receipt of your payment, CFAC will forward a copy of the last two years of your medical record to the physician/facility you have designated.

Consent to Treat/Acknowledgement of Financial Responsibility

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Centers for Foot and Ankle Care to render needed treatment and/or tests to the patient.
2. I authorize Centers for Foot and Ankle Care to release any information required for payment of insurance claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services.
4. I understand that I am responsible for all charges incurred through Centers for Foot and Ankle Care. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given Centers for Foot and Ankle Care's handout on missed appointments and understand my responsibilities regarding being late or absent.
6. Parent or legal guardian consent must be provided for treatment of a child (under the age of 18) for every visit. If you are unable to accompany your child to each visit, you may designate specific person(s) (adults over age 18) below as giving consent to treat for your child on your behalf.

   Name _____ Relation to child _____

7. In the event of an emergency, I designate the following person as my emergency contact:

   Name _____ Home phone _____

   Address _____ Other phone _____

   City/State/ Zip _____

8. Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

_____ _____

Signature of Patient or Legal Guardian **Date**

Notice of Privacy Practices Acknowledgement

I have received or been offered copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian **Date**

CFAC CENTERS FOR Foot & Ankle Care

Registration Form

Last Name	First Name	MI	Nickname	DOB	Account Number (Office)

Street Address	City	State	ZIP Code

Home Phone	Work Phone	Cell Phone	Social Security #

Sex: ☐ Male ☐ Female	Email Address

Emergency Contact	Contact Phone	Primary Care Physician

PRIMARY Insurance Name	Copay $	SECONDARY Insurance Name	Copay $

Claims Address P.O. Box	Claims Address P.O. Box

Subscriber's Name	Subscriber DOB	Subscriber's Name	Subscriber DOB

Subscriber's ID No.	Group No.	Subscriber's ID No.	Group No.

How did you hear about our practice?
☐ Family ☐ Friend ☐ Newspaper ☐ Radio ☐ TV ☐ Phone Book ☐ CFAC Website
☐ Internet ☐ Signage ☐ Insurance Directory ☐ Other Physician ☐ Hospital

Please provide the following information so we may improve patient communication and care.

Primary Language (select one)
☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ German ☐ Hindi ☐ Urdu
☐ Japanese ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Spanish

Ethnicity	Race ☐ Hispanic or Latino
☐ Hispanic or Latino ☐ NOT Hispanic or Latino	☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

Complete this section ONLY if the patient is under 18 years old.

Last Name	First Name	Social Security #	Relationship to Patient

Street Address	City	State	ZIP Code

Home Phone	Work Phone	Cell Phone	Gender

The undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.

Signature _____ Date _____

MEDICAL HISTORY

Name: _____ Date:_____

Describe the conditions of your foot concern: _____

Whom may we thank for referring you to us? _____

List allergies: (__None)

ALLERGY #1

Common: __ Adhesive __Erythromycin Base __Iodine Dyes __Latex __Lidocaine __Penicillin __Sulfa
Food/Medication/Other: _____ Severity: __Mild __Moderate __Severe
Describe allergic reaction: _____

ALLERGY #2

Common: __ Adhesive __Erythromycin Base __Iodine Dyes __Latex __Lidocaine __Penicillin __Sulfa
Food/Medication/Other: _____ Severity: __Mild __Moderate __Severe
Describe allergic reaction: _____

ALLERGY #3

Common: __ Adhesive __Erythromycin Base __Iodine Dyes __Latex __Lidocaine __Penicillin __Sulfa
Food/Medication/Other: _____ Severity: __Mild __Moderate __Severe
Describe allergic reaction: _____

List medications and **dosage** you are taking:

1._____ / _____ 4._____ / _____ 7._____ / _____

2._____ / _____ 5._____ / _____ 8._____ / _____

3._____ / _____ 6._____ / _____ 9._____ / _____

IMMUNIZATION HISTORY

When was your last tetanus booster shot? _____

MEDICAL HISTORY

Y__ N__ Anemia	Y__ N__ Anxiety	Y__ N__ Arthritis	Y__ N__ Asthma
Y__ N__ Back Problems	Y__ N__ Breast Cancer	Y__ N__ COPD	Y__ N__ Cancer
Y__ N__ Cholesterol High	Y__ N__ Congestive Heart F	Y__ N__ Coronary Disease	Y__ N__ Dementia
Y__ N__ Depression	Y__ N__ Dermatitis	Y__ N__ Diabetes	Y__ N__ Diabetes Mellitus 1
Y__ N__ Diabetes Mellitus 2	Y__ N__ Enlarged Prostate	Y__ N__ Epilepsy	Y__ N__ GERD
Y__ N__ Glaucoma	Y__ N__ Gout	Y__ N__ HIV	Y__ N__ Headache
Y__ N__ Hearing Problem	Y__ N__ Heart Attack (MI)	Y__ N__ Heart Disease	Y__ N__ Hemorrhoids
Y__ N__ Hepatitis	Y__ N__ Hypertension	Y__ N__ Kidney Disease	Y__ N__ Liver Disease
Y__ N__ Migraine	Y__ N__ Pneumonia	Y__ N__ Renal Stone	Y__ N__ Rheumatoid Arthritis
Y__ N__ Stroke	Y__ N__ TB	Y__ N__ Thyroid	Y__ N__ Ulcer (GI)

Other: _____

Patient Name _____

Last Seen

Primary Care Physician (PCP) _____

If diabetic, what was the last date seen by your PCP? _____

Have you been treated for foot problems in the past? When? _____ Why?_____

Shoe Size	Height	Weight
Patent shoe size _____	___Feet ___Inches	_____ Pounds

REVIEW OF SYSTEMS: Indicate yes or no if you have any of the following problems on a regular basis:

Constitutional:
Y__ N__ Chills
Y__ N__ Fatigue
Y__ N__ Fever
Y__ N__ Weakness

Head:
Y__ N__ Dizziness
Y__ N__ Fainting
Y__ N__ Headaches

Respiratory:
Y__ N__ Cough
Y__ N__ Wheezing

Cardiovascular:
Y__ N__ Chest Pain
Y__ N__ Cramps in Legs/Feet
Y__ N__ Extremity (s) Cool
Y__ N__ Hair Loss On Legs
Y__ N__ Heart Murmur
Y__ N__ High Blood Pressure
Y__ N__ History of MI
Y__ N__ Leg or Foot Ulcers
Y__ N__ Palpitations
Y__ N__ Replace. Heart Valve
Y__ N__ Rheumatic Fever
Y__ N__ Shortness of Breath
Y__ N__ Varicose Veins
Y__ N__ Vascular Grafts

Gastrointestinal:
Y__ N__ Constipation
Y__ N__ Diarrhea
Y__ N__ Heartburn
Y__ N__ Hepatitis
Y__ N__ Jaundice
Y__ N__ Liver Disease
Y__ N__ Nausea

Musculoskeletal:
Y__ N__ Ankle Sprain
Y__ N__ Arch Pain
Y__ N__ Arthritis
Y__ N__ Back Problems
Y__ N__ Broken Ankle
Y__ N__ Broken Foot Bone
Y__ N__ Bunions
Y__ N__ Calluses
Y__ N__ Childhood Foot Prob
Y__ N__ Flat Feet
Y__ N__ Gait (Walking) Prob.
Y__ N__ Gout
Y__ N__ Hammer/Mallet Toes
Y__ N__ Heel Pain
Y__ N__ High Arch Feet
Y__ N__ In-toeing
Y__ N__ Joint implants
Y__ N__ Joint Pain
Y__ N__ Joint Stiffness
Y__ N__ Knee Pain
Y__ N__ Muscle Cramps
Y__ N__ Neuroma
Y__ N__ Orthotic Use
Y__ N__ Paralysis
Y__ N__ Toe Walking

Psychiatric:
Y__ N__ Depression

Skin:
Y__ N__ Athlete's Foot
Y__ N__ Dryness
Y__ N__ Eczema
Y__ N__ Fungal Nails
Y__ N__ Hives
Y__ N__ Ingrown nails
Y__ N__ Itching
Y__ N__ Keloid Scar
Y__ N__ Lumps
Y__ N__ Mole Changes
Y__ N__ Rash
Y__ N__ Warts

Neurological:
Y__ N__ Burning
Y__ N__ Charcot Neuropathy
Y__ N__ Numbness
Y__ N__ Strokes
Y__ N__ Tingling
Y__ N__ Tremors
Y__ N__ Unsteady Gait

Endocrine:
Y__ N__ Thyroid
Y__ N__ Weight Gain
Y__ N__ Weight Loss

Hematologic/Lymph:
Y__ N__ Anemia
Y__ N__ Bleeding Easily
Y__ N__ Blood Clots
Y__ N__ Easy Bruisability
Y__ N__ Rec. Chemotherapy
Y__ N__ Slow-healing Cuts
Y__ N__ Swollen Glands
Y__ N__ Transfusion React.

Eye:
Y__ N__ Blurred Vision
Y__ N__ Eyeglasses
Y__ N__ Glaucoma

FAMILY HISTORY
(Immediate family only.)

	Mother	Father	Sister	Brother	Other
Living	__	__	__	__	__
High Blood Pressure	__	__	__	__	__
Diabetes	__	__	__	__	__
Heart Disease	__	__	__	__	__
High Cholesterol	__	__	__	__	__
Glaucoma	__	__	__	__	__
Cancer	__	__	__	__	__

Type of Cancer : _____

Other:_____ __ __ __ __ __

OBSTETRICS HISTORY
Women: Are your pregnant or nursing? Y__ N__

SOCIAL HISTORY

Tobacco	Usage Status	Last Used	Daily Usage	Years	Cessation Attempts	Last Cessation Rx
Cigarettes	__Never __Former __Active					
Other _____	__Never __Former __Active					

Alcohol Type	Usage Status	Last Used	Usage #	Measurement Time
_____	__Social __Occasional __Light __Heavy			__Day __Week __Month

Education-Occupation	Answer	Notes
Work Industry	__Agriculture __Construction __Domestic Services __Household __Industrial __Management __Office	Job Title: _____

Household	Answer	Notes
Marital Status:	__Single __Married __Civil Union __Domestic Partnership __Common Law Marriage __Separated __Divorced __Widowed	

Substance Use	Answer	Notes
Have you ever used any illegal drugs?	__Never Used __Current User __Prior User __Current Treatment Program __Maintaining Sobriety	
Drug(s): _____		How long have you been sober? _____
How do you use these drugs?	__Inject __Inhale (Smoke) __Intranasal (Snort) __Transdermal (Placed on Skin) __Buccal (Dissolve Between Cheek and Gums) __Sublingual (Dissolve Under Tongue) __Chew __Oral (Swallow)	

Surgical History

Y__ N__ Diabetic Foot Ulcer	Y__ N__ Aortic Aneurysm	Y__ N__ Appendectomy	Y__ N__ Carotid Endaterect.
Y__ N__ Cholecystectomy	Y__ N__ Colectomy	Y__ N__ Coro. Angioplasty	Y__ N__ Coronary Bypass
Y__ N__ Foot Surgery	Y__ N__ Fracture	Y__ N__ Gall Bladder	Y__ N__ Heart Valve
Y__ N__ Hernia Abdominal	Y__ N__ Hip Fracture	Y__ N__ Hip Surgery	Y__ N__ Intestinal Bypass
Y__ N__ Knee Arthroscopy	Y__ N__ Knee Surgery	Y__ N__ LS Spine Surgery	Y__ N__ Mastectomy
Y__ N__ Oophorectomy Uni.	Y__ N__ PVD Procedure	Y__ N__ Pacemaker	Y__ N__ Prior Surgeries
Y__ N__ Prostate Surgery	Y__ N__ Shock Wave Lithotrip.	Y__ N__ Shoulder Arthrosc.	Y__ N__ Shoulder Surgery
Y__ N__ Splenectomy	Y__ N__ Thyroidectomy		

Other:_____

Pharmacy 1: Name _____ Location _____ Phone (if known) _____

Pharmacy 2: Name _____ Location _____ Phone (if known) _____

Consent For Treatment

The above information is correct to the best of my knowledge. I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary by the doctor(s).

_____ _____ _____

Signature of Patient or Consenter Date Witness Signature

CFAC
CENTERS FOR
Foot & Ankle Care

Vascular & Neurological Assessment Form

If you are over 65, or have diabetes, or smoke, or have known heart disease, please complete the following screening form:

Name: _____

Date: _____

Office: _____

1.	Do you have diabetes? If yes, how long? _____ years. ☐ Type 1 ☐ Type 2	☐ Yes	☐ No
	If you answered yes, have you been diagnosed with diabetic peripheral neuropathy from an EMG or other nerve conduction test? _____years ago.	☐ Yes	☐ No
2.	Do you have high blood pressure?	☐ Yes	☐ No
3.	Do you have high cholesterol?	☐ Yes	☐ No
4.	History of smoking?	☐ Yes	☐ No
5.	When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks?	☐ Yes	☐ No
	If you answered yes, does the pain subside with rest?	☐ Yes	☐ No
6.	Do you have any painful sores or ulcers on your legs or feet that aren't healing?	☐ Yes	☐ No
7.	Have you experienced temporary loss of vision in one eye?	☐ Yes	☐ No
8.	Have you experienced temporary slurred speech?	☐ Yes	☐ No
9.	Have you ever had stent placement, balloon procedure or by-pass surgery in the arteries surrounding your heart?	☐ Yes	☐ No
10.	Do you have swelling in your legs, feet?	☐ Yes	☐ No
11.	Increased sensitivity to touch in your feet?	☐ Yes	☐ No
12.	Are your hands or feet cold to the touch?	☐ Yes	☐ No
13.	Do you have numbness or tingling in your arm(s), leg(s) or feet?	☐ Yes	☐ No
14.	Do your legs or feet fall asleep regularly?	☐ Yes	☐ No
15.	Do you have reduced feeling (hot/cold sensation) in your legs, feet?	☐ Yes	☐ No
16.	Pain or burning in your feet?	☐ Yes	☐ No
17.	Trouble feeling your feet when you walk?	☐ Yes	☐ No
18.	Discomfort or pain at night in your feet?	☐ Yes	☐ No
19.	Other _____		

Patient Authorization for Personal Representative

Form 7.30

Please print all information, then sign and date form at bottom.

Name of Practice: Centers For Foot & Ankle Care

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

_____

Name of Personal Representative Phone

_____

Address

_____

City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Centers For Foot & Ankle Care

25 Merchant Street, Suite 220

Cincinnati, OH 45246

Attn: Privacy Manager.

Redisclosure: We have no control over the person(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

Copies of signed authorizations are available upon request.

Patient Non-Discrimination Statement

July 2011

The Centers for Foot and Ankle Care is dedicated to providing quality health care services to our patients. In doing so, it is our commitment and policy that the delivery of quality health care services will be provided to anyone, regardless of race, ethnicity, national origin, religion, sex or age.

Centers for Foot and Ankle Care does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, ethnicity, national origin, religion, sex or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by our practice, directly or through a contractor or any other entity with which Centers for Foot and Ankle Care arranges to carry out our services, programs or activities.

Should you have any questions regarding our non-discrimination statement and policy, would like to request a full copy of the CFAC non-discrimination policy or if you believe that you may have been subjected to discrimination as defined in this policy statement and you wish to file a formal complaint, you may do so by contacting the Practice Manager of this office location. If you wish to file a formal complaint with a representative not associated with the local office practice, you may do so by contacting CFAC Human Resources Department, 25 Merchant Street, Suite 220, Cincinnati, Ohio 45246. Telephone 513-533-1179.

An expeditious investigation into the complaint and allegations will be conducted. If it is found that our commitment has been violated, appropriate action will be taken based on such violation.

Filing a complaint through this office or through Human Resources does not prevent you from filing a formal complaint with the state agency. Should you wish to file a formal complaint with the agency, you may do so by contacting:

For patients seen in an Ohio office:

The Ohio Civil Rights Commission
801 Plum Street, Room 158
Cincinnati, Ohio 45202

For patients seen in an Indiana office:

The Indiana Civil Rights Commission
100 North Senate Ave., Room N103
Indianapolis, IN 46204

Sincerely,

Nicholas J. Minnie
President
Centers for Foot and Ankle Care

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 follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose 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 the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised 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 within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. 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 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 inspect, and obtain a copy of your complete health record. 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 fee for paper or electronic copies as established by professional, state, or federal guidelines.

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 office.

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, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

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.

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. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

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.

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 neceesary 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, 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 for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; 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. You may file a complaint with us by notifying the Privacy Manager at:

25 Merchant Street, Suite 220 , Cincinnati, OH 45246

We will not retaliate against you for filing a complaint.

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