cope center for colorectal & pelvic health

Clifton L. Cox, M.D.

Welcome Back!

Many things have changed, and some have remained the same…
On behalf of Dr. Clifton L. Cox, we welcome you back to our practice. Since we have last seen you, many things have changed, but some have remained the same. We remain committed to our mission:

> ***We strive to provide compassionate, personalized, evidence-based treatment to maximize your colorectal and pelvic floor health.***

We are excited about the many changes to our practice, and look forward to hearing your comments on them. We are very proud of our **new facility**, which has been built expressly for the needs of our patients. For most, it is easier to get to, and the design is the culmination of 18 years experience in providing specialized care to colorectal and pelvic floor patients.

We have **renamed the practice** to reflect the broader scope of services we provide. We are now the **COPE Center for Colorectal and Pelvic Health**, which reflects both the **CO**-lorectal and **PE**-lvic health aspects of our clinic. We can now provide under one roof a full range of diagnostic and treatment options to patients, including pelvic floor physical therapy, non-operative treatment of anorectal conditions, and more complex colon and pelvic floor surgical procedures. We will continue to do all outpatient surgery at Baylor Surgicare - Grapevine and the beautiful new private facility, Forest Park Medical Center in Southlake. We also perform more complex inpatient surgeries at Forest Park Medical Center as well as Baylor Regional Medical Center – Grapevine.

In order to make your time in the office as efficient as possible, we have enclosed a set of patient forms for you to update. Not only do these forms fulfill the regulatory requirements required to see you, they provide important clinical information that will optimize your care. We hope that by completing these forms in the comfort and privacy of your own home, you will take the time to answer as honestly and thoroughly as possible. Please bring the completed packet at least 10 minutes prior to your appointment, along with proof of insurance, a photo ID, a list of all the medications you are taking and any other information you feel may be pertinent.

Cancellation or Rescheduling Appointments
We are generally booked well in advance for all patient appointments. Please check all calendars to be sure your appointment date and time work. We ask that you notify us 24 hours in advance to cancel or reschedule an appointment. This will enable us to schedule someone else in that valuable time spot.

Directions
Our office is located at 300 S. Nolen Drive Suite 100 in Southlake, TX.
From Hwy 114, Exit Kimball Avenue and turn South. Go to the next intersection, Southlake Blvd (FM 1709), and turn East (left) then turn South (right) at S. Nolen Dr. (Starbucks is on the corner). We are on the right hand side of the street.

On Mapquest, you can find us at: http://mapq.st/1j0JXhr.

On Google Maps the link is: http://goo.gl/maps/Pm5br

We look forward to seeing you soon!

cope center for colorectal & pelvic health

Patient Information Sheet

Personal Information

Last Name: | First: | MI: | Date:

Name you wish to be called/nickname: | Social Security #:

Drivers License # and State: | Date of Birth: | Gender: Male Female

Home Address:

Mailing Address (if different) : | Email Address:

Please circle your current marital status: Single Married Divorced Widowed Separated

Employment status: Full-time Part-time Not Employed Self Employed Retired Active Duty Military

Employer Name: | Student Status: Full-Time Part-Time Not A Student

Employer's Address:

Spouse/Partner's Name: | Birthdate: | Work #:

Telephone Preferences

Home: | Work: Ext: | Cell:

In the event of an emergency, who should we contact? Name:

Relationship: | Home #: | Work #:

Health Insurance

Primary Insurance Co. Name: | Customer Service #:

Member/Subscriber ID#: | Group/Account/Plan#:

Claims mailing address:

Name of Policyholder: | Policyholder's relationship to patient:

Policyholder's address (if different):

Policyholder's social security #: | Policyholder's date of birth:

Is insurance coverage obtained through an employer? YES NO | Policyholder's employer:

Secondary Insurance Co. Name: | Customer Service #:

Member/Subscriber ID#: | Group/Account/Plan#:

Claims mailing address:

Name of Policyholder: | Policyholder's relationship to patient:

Policyholder's address (if different):

Policyholder's social security #: | Policyholder's date of birth:

Is insurance coverage obtained through an employer? YES NO | Policyholder's employer:

Additional Insurance Co. Name: | Member ID#:

Group/Account/Plan #: | Name of Insured: | Relationship:

Claims mailing address:

Referrals

PCP/Family Physician: | City: | Phone #:

Referring Physician: | City: | Phone #:

Additional Physician: | City: | Phone #:

Pharmacy: | Phone #: | Cross streets:

How did you hear about us?

cope center for colorectal & pelvic health

General Health Information

Is your general health? (Please circle) Excellent Good Average Fair Poor

Do you exercise currently? (Please circle) No 1-2 days/week 3-4 days/week 5+ days/week

Current exercise description: _____

Do you smoke cigarettes? No Yes Approximate # per day _____ How many years? _____

Do you drink alcohol? No Yes Approximately (#) _____ drinks per week/month (circle) _____

Caffeine intake: None Approximately (#) _____ including coffee, tea, soft drinks, etc. per day

Past surgical history & hospitalizations (include approximate dates):

_____

_____

Please list al medications that you are currently taking and their doses, including aspirin and any over-the-counter or herbal medications.

Medication	Approximate start date	Reason for taking

Please list all medication you are allergic to and your reaction to the medication

☐ No known drug allergies _____

_____

Do you currently have or have ever had problems with any of the following? Please check all that apply. Please use the space provided below to describe if necessary.

General
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Raynaud's
- ☐ Headaches
- ☐ Hearing loss/problems
- ☐ Falls

Urologic/Gynecologic
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Interstitial cystitis
- ☐ Childhood bladder problem
- ☐ Sexually Transmitted Disease
- ☐ Organ Prolapse

Hematologic
- ☐ Anemia
- ☐ Blood disorder

Cardiovascular
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart attack
- ☐ High cholesterol

Abdominal/GI
- ☐ Hernia
- ☐ Nausea or vomiting
- ☐ Reflux
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hormonal abnormalities
- ☐ Steroid use

Latex Allergy? Yes No

Rheumatologic/Orthopedic
- ☐ Back pain
- ☐ Joint pain
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Joint replacement
- ☐ Sports Injuries
- ☐ Bone/Stress Fracture

Neurological/Psychiatric
- ☐ Stroke
- ☐ Seizure
- ☐ Anxiety
- ☐ Phobia
- ☐ Depression
- ☐ Alzheimer's
- ☐ Parkinson's

Oncologic
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Cancer

Other

_____

_____

_____

_____

_____

Primary Care Physician

_____

_____

_____

Other Physicians

_____

_____

_____

Referring Physician- Name/Specialty: _____

☐ Check here if self-referral

Employment Status

Which of the following best describes your current job status?

- ☐ Employment outside the home full-time
- ☐ Employed outside the home part-time _____ hours/week
- ☐ Homemaker
- ☐ Disabled
- ☐ Primary caretaker of children
- ☐ Retired
- ☐ Unemployed

General Functional Information

Please check all that apply:

- ☐ Difficulty falling asleep-Typical time you go to bed:_____
- ☐ Waking up during the night -Number of times: _____
  - Reason for waking during the night:
  - ☐ Need to go to the bathroom ☐ Pain/Discomfort ☐ Worry ☐ Other
- ☐ Tired/fatigued upon waking up in the morning -typical time you wake up: _____
- ☐ Currently sexually active -Approximate frequency: _____
- ☐ Previously sexually active

Since the onset of your current symptoms have you had:

- ☐ Fever/chills
- ☐ Unexplained weight change
- ☐ Dizziness or fainting
- ☐ Change in bowel or bladder function
- ☐ Malaise (Unexplained tiredness)
- ☐ Unexplained muscle weakness
- ☐ Night pain
- ☐ Night sweats
- ☐ Numbness/Tingling

Other: _____

Rate the severity on a scale of 0 (did not interfere) to 10 (completely interfered) of how this problem has interfered with the following over the past month:

- ☐ General activity
- ☐ Social activity
- ☐ Normal work (including housework)
- ☐ Sleep
- ☐ Diet and/or fluid intake Describe: _____
- ☐ Physical Activity
- ☐ Enjoyment of life
- ☐ Mood
- ☐ Relations with other people
- ☐ Ability to have sexual relations
- ☐ Other: _____

What are your treatment goals and/or concerns? _____

_____

Do you have a history of sexual abuse? ☐ Yes ☐ No

Do you have a history of physical abuse? ☐ Yes ☐ No

Do you now or have you ever participated in counseling or psychological therapies to address any abuse history? ☐ Yes ☐ No

Symptom Information

Please describe the problem/symptoms that brought you here (continue on back if needed): _____

_____

_____

How long have you had these symptoms? _____ years _____ months _____ weeks

Is there an event you associate with the onset of your symptoms? ☐ No ☐ Yes

If yes, please describe (include date): _____

_____

_____

Since that time are the symptoms: ☐ staying the same ☐ getting worse ☐ getting better

My symptoms are made worse, aggravated, increased by:

- ☐ Sitting greater than _____ minutes
- ☐ Walking greater than _____ minutes
- ☐ Standing greater than _____ minutes
- ☐ Changing positions (ex. Sit to stand)
- ☐ Light physical activity
- ☐ Vigorous activity
- ☐ Coughing/Straining/Sneezing
- ☐ Laughing/Yelling
- ☐ Lifting/bending
- ☐ Triggers (ex. key in door, running water)
- ☐ Contact with clothing
- ☐ Ovulation
- ☐ Menstruation
- ☐ Sexual intercourse
- ☐ Cold weather
- ☐ Full bladder
- ☐ Emptying my bladder
- ☐ Need to have a bowel movement
- ☐ Having a bowel movement
- ☐ Tampon use
- ☐ Pap smear
- ☐ Cold weather
- ☐ Nervousness/anxiety
- ☐ Stress
- ☐ Other

My symptoms are made better, relieved, decreased by: _____

_____

_____

Past treatments and their effects (helpful or not helpful) include: _____

_____

_____

Urinary Symptoms/History

Do you experience any of the following? Check all that apply.

- ☐ Loss of urine with coughing, sneezing, straining
- ☐ Loss of urine with jumping, running, or exercise
- ☐ Loss of urine with urinary urgency
- ☐ Trouble initiating the urine stream
- ☐ Slow urine stream (start/stop)
- ☐ Intermittent urine stream (start/stop)
- ☐ Difficulty passing urine
- ☐ Straining or pushing to empty your bladder
- ☐ Constant urine leaking
- ☐ Blood in your urine
- ☐ Painful urination
- ☐ Painful bladder following urination
- ☐ Difficulty feeling bladder urgency/fullness
- ☐ Feeling of urgent within minutes of voiding

How many times DURING THE DAY do you go to the bathroom to void/empty your bladder?

☐ 3-6 ☐ 7-10 ☐ 11-14 ☐ 15-19 ☐ 20+

How many times AT NIGHT do you go to the bathroom to void/empty your bladder?

☐ none ☐ 1 ☐ 2 ☐ 3 ☐ 4+

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

☐ not at all ☐ 5-10 minutes ☐ 15-30 minutes ☐ 35-60 minutes

When you urinate the typical amount passed is: ☐ small ☐ medium ☐ large

Number of episodes of loss of urine:

- ☐ No leaking
- ☐ _____ Times per day
- ☐ _____ Times per week
- ☐ _____ Times per month
- ☐ _____ only with physical exertion

Typical volume of urine loss per episode:

- ☐ No leaking
- ☐ Entire contents of bladder
- ☐ Just a few drops
- ☐ West underwear
- ☐ Requires pad/protection

What form of pad/protection do you wear?

- ☐ None
- ☐ Minimal (tissue paper, paper towel, pantishield)
- ☐ Moderate (maxipad)
- ☐ Maximum (specialty product)
- ☐ Other _____

Number of pads/day= _____

Typical % of pad full at each change=_____

Do you have a history of urinary tract infections? ☐ Yes ☐ No Approximate # per year_____

GI/Bowel Symptoms/History

Do you experience any of the following? Check all that apply.

- ☐ Pain with bowel movement
- ☐ Constipation
- ☐ Straining with bowel movements
- ☐ Less than 3 bowel movements per week
- ☐ Hard or lumpy stools
- ☐ Hemorrhoids
- ☐ Feeling of incomplete emptying with bowel movement
- ☐ Laxative use
- ☐ Trouble holding back gas
- ☐ Bowel leaking
- ☐ Frequent diarrhea
- ☐ Loose or watery stools
- ☐ More than 3 bowel movements per day
- ☐ Blood in stool
- ☐ Bowel urgency
- ☐ Decrease in pain after a bowel movement
- ☐ Frequent nausea
- ☐ History of anorexia

Number of bowel movements per day/week: _____

Current constipation management techniques: _____

How would you describe your diet?

☐ Well-balanced ☐ Typical American ☐ Low-Carbohydrate ☐ Low-Fat

☐ Special Diet _____ ☐ Other _____

Number of episodes of bowel leaking:
- ☐ No leaking
- ☐ _____ times per day
- ☐ _____ times per week
- ☐ _____ times per month
- ☐ _____ only with strong urge

Typical amount of stool leakage per episode:
- ☐ No leaking
- ☐ Stool staining
- ☐ Small amount in underwear
- ☐ Complete emptying
- ☐ Requires pad/protection

Date of last colonoscopy: _____

Males Only

Please check all of the following that apply and complete each.

- ☐ Prostate disorder - Describe _____
- ☐ Shy bladder
- ☐ Pelvic pain
- ☐ Vasectomy - Date _____
- ☐ Post-vasectomy pain syndrome
- ☐ Erectile dysfunction
- ☐ Pain with ejaculation
- ☐ Pain following ejaculation
- ☐ Testicular pain
- ☐ Other _____

Females Only

Please check all of the following that apply and complete each.

- ☐ Taking birth control pills or using other birth control methods _____
- ☐ Pain before periods start (_____ days before)
- ☐ Pain during periods ☐ Minimal ☐ Moderate ☐ Severe
- ☐ Pain during ovulation
- ☐ Menopause (approximate start and end dates:_____)
- ☐ Hormone Replacement Therapy- Type: _____
- ☐ Hysterectomy ☐ Complete ☐ Ovaries remaining -Date _____
- ☐ History of yeast infections - Approximate # per year: _____
- ☐ Feelings of heaviness, pressure or falling out in the vaginal/pelvic area?
- ☐ Prior diagnosis of prolapse - date and type: _____
- ☐ Vaginal dryness
- ☐ Pain with sexual intercourse ☐ Initial penetration ☐ Deep penetration ☐ Movement
- ☐ Pain with orgasm
- ☐ Irregular menstruation
- ☐ Ovarian cysts
- ☐ Vaginal discharge
- ☐ Endometriosis

How many pregnancies have you had?

Resulting in: _____ vaginal deliveries _____ caesarean deliveries _____miscarriage _____abortion

Please check all of the following that apply.

- ☐ Episodes of urinary leaking/incontinence during pregnancy
- ☐ Pelvic pain during pregnancy
- ☐ Low back pain during pregnancy
- ☐ Complications during pregnancy - Describe
- ☐ Complications during delivery - describe
- ☐ Episiotomy
- ☐ Tearing during delivery

Date of last paper smear: _____

_____ _____

Patient Signature Date

_____ _____

PT Signature Date

cope center for colorectal & pelvic health

Conditions and Consent for Pelvic Physical Therapy Evaluation and Treatment

I understand that I am a patient of the healthcare providers of the COPE Center for Colorectal & Pelvic Health including medical director Clifton Cox, MD, the physical therapists and clinical staff.

Cooperation with Treatment
In order for physical therapy treatment to be effective, I must attend scheduled appointments barring any unusual circumstances. I agree to cooperate with and perform the home physical therapy program. If I have trouble with any part of my treatment program, I will discuss it with my physical therapist.

No Warranty
I understand that the physical therapist cannot make promises and that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss her opinions regarding potential results and goals of physical therapy treatment for my condition, and will discuss treatment options with me before I verbally consent to treatment.

Informed Consent for Evaluation and Treatment
The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to me. I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to: pelvic pain conditions, urinary or fecal incontinence, difficulty with bowel or bladder functions, sexual dysfunction including but not limited to pain with intercourse, painful scars or adhesions following childbirth or surgery, persistent sacroiliac or low back pain, or pain in the tailbone area.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my physical therapist perform and internal pelvic floor muscle, connective tissue, and visceral examination. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, connective tissue mobility, scar mobility, and the function of the pelvic floor region. Such evaluation and examination may include external or internal vaginal or rectal sensors for muscle biofeedback.

I understand that physical therapy treatment may include, but not be limited to the following: observation, internal vaginal/rectal and external manual therapy (connective tissue manipulation, trigger point release, myofascial release, soft tissue mobilization, muscle energy techniques, and/or joint mobilization). Palpation, neuromuscular re-education and motor control training, external or internal vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, and educational instruction.

Potential Risks
I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary. If it does not subside in the timeframe estimated by my physical therapist I agree to contact my physical therapist.

Potential Benefits
I may experience any improvement in my symptoms and an increase in my ability to perform daily activities. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives
If I do not wish to participate in the physical therapy program, I will discuss this with my physical therapist and pursue discussion of any medical, surgical or pharmacological alternatives with my physician or primary care provider.

Disclosure
I have informed my physical therapist of any condition that would limit my ability to have an evaluation/examination or to be treated. I hereby request and consent to the evaluation/examination and treatment to be provided by the physical therapists of COPE.

_____ _____
Patient Signature Date

_____
Patient Name Printed

_____ _____
Witness Signature Date

Office Financial Policy

It is the policy of this office to receive payment at the time that services are rendered.

We strive to provide the utmost in care and minimize any difficulties in the processing of medical billing. We participate in most insurance plans, including Medicare.

If we are a participating provider for your insurance company, the co-pay or the insured's responsibility is due at the time of the office visit.

If you are insured by a plan we do business with, but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage.

Knowing your benefits is your responsibility. We will do our best to provide an accurate estimate of the costs of services prior to your appointment. Please be aware, however, that these are just estimates and may not reflect actual costs. Please contact your insurance company with any questions you may have regarding your coverage.

If you are not insured by a plan we do business with, payment in full is expected at each visit unless other arrangements have been made in advance.

Referrals are the patient's responsibility. In the event that an insurance claim is denied because of failure to obtain a referral, the fees for services will be the patient's responsibility.

Fees for planned surgeries require 50% deposit and will be filed with your insurance company. We will pre-certify all surgeries for you.

Should you be hospitalized and under our care, doctor's fees while you are hospitalized will be billed to your insurance company. All funds received from your insurance company will be promptly applied to your balance.

We will bill you three times for overdue bills. If the outstanding balance is not paid after three statements, we will send the account to a collections agency for processing. For all unpaid balances, a handling fee of $10.00/month will be added to your balance commencing with the second month of billing.

Treatments may not be covered under some insurance policies and prompt payment is the patient's responsibility.

If you are covered by two insurance policies, you will be required at the time of service for the co-pay from the primary provider. We do not process claims for co-pays. However, we will provide a receipt after the primary insurance pays the claim for you to submit to your secondary policy.

As a courtesy, we will file claims for your primary and secondary insurance. You are responsible for claims with any additional providers.

I have read and understand the Financial Policy above.

_____ _____

Legal Signature Date

cope center for colorectal & pelvic health

My signature below is acknowledgement of receipt of the
Notice of Privacy Practices from this office

Name of Patient (please print)	Signature of Patient	Date

Signature of Patient Representative (required if patient is a minor or unable to sign)	Relationship to Patient	Date

Persons Authorized to Receive Information

Name of Person	Relationship	Date of Birth
Name of Person	Relationship	Date of Birth
Name of Person	Relationship	Date of Birth

_____ (please initial) I authorize the person(s) listed above to receive *all health information* about appointments, treatment, insurance, and/or other information contained in my records.

_____ (please initial) I do not authorize the following information to be released to anyone other than myself: (please specify) _____

Telephone Preferences

Please give us permission or denial for calling you in reference to appointments, schedule changes, etc. We do not give out medical information except to you and your authorized representatives, and we do not leave sensitive information on a message.

Please circle your responses

May we call you at your home number?	YES	NO	N/A	May we leave a message?	YES	NO	N/A
May we call you at your work number?	YES	NO	N/A	May we leave a message?	YES	NO	N/A
May we call you at your mobile number?	YES	NO	N/A	May we leave a message?	YES	NO	N/A

Signature of Patient or Patient Representative	Date

cope center for colorectal & pelvic health

Clifton L. Cox, M.D.

Patient/Provider Care Agreement

Practice Responsibilities

- We will strive for excellence in all aspects of patient care.
- We will treat you with the utmost of respect and courtesy.
- We will be professional and discrete when caring for you.
- We will be respectful of your time and always strive to keep your scheduled appointment time, with the understanding that unforeseen emergencies, on occasion, make this impossible.
- We will submit claims to insurance companies with whom our office has agreements.
- We will communicate with you in a clear and timely manner.
- We will share your medical information only with appropriate medical personnel and those that you specifically designate.
- We will keep thorough records of the care you receive from us.
- We will assist you in providing copies of your medical records or assist you in completing forms for a reasonable fee.

Patient Responsibilities

- Patients will be responsible for the payment of any additional deductible, co-insurance or co-pay at time of service.
- Patients are ultimately responsible for knowing and understanding their insurance plan benefits and how they will be applied to the various services they may be provided.
- Patients should provide accurate insurance information prior to the initial visit, along with updates as necessary.
- Patients must consent to the release of medical information to all pertinent insurance companies, plan administrators, third party payers, and claim reviewers.
- Patients are ultimately responsible for obtaining referrals from Primary Care Physicians when necessary. We will assist with this process as we are able.
- Patients should arrive for appointments in a timely fashion, and 30 minutes prior to the initial visit to complete paperwork.
- Patients must provide at least (24) hour notice for appointment cancellation. Failure to provide this notice prevents us from offering your valuable spot to someone who needs it and therefore a $40.00 fee will be assessed.
- Patients should cooperate fully with the doctor, therapists, and staff in carrying out the designated treatment plan.
- Patients will complete (or update) a Patient Demographics Form every 6 months.
- Patients will notify our office of changes to personal information and/or insurance carriers.
- Patients are ultimately responsible for understanding their obligations to other providers of medical care such as hospitals, outpatient facilities, labs, anesthesia and pathology providers. These entities will bill separately and are not subject to any direction from our practice.
- Patients are ultimately responsible for prior authorization and pre-certification as may be required by the insurance companies. We will assist with this process as we are able.
- In respect of others and in order to assure complete focus, patients will refrain from bringing children to their appointments.

By signing below, you understand the above responsibilities and agree that they are valid and provide your consent to treat. If you do not understand these responsibilities or need further clarification, please ask a staff member before signing.

Signature _____ Date _____

cope center for colorectal & pelvic health

Clifton L. Cox, M.D.

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Signature _____ Date _____

Notice of Privacy Practices

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

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future. We may use or disclose limited amounts of your protected health information to send you fundraising materials. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information for which we would receive compensation would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes" or is for marketing purposes.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPAA and HITECH regulations. We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services
You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of September 23, 2013.

Patient Signature_____Date_____