



Ketamine Infusion Center

Our Commitment to You

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.
- If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that you keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- We are sorry, but due to the high fax volume we are **NOT** able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will **NOT** be seen by the doctor and your appointment will be **RESCHEDULED**.
 1. Photo ID
 2. MRI films and reports, CT scan films and reports, bone scan reports
 3. EMG reports
 4. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
 5. List of current medications

Financial Policy

- We are committed to providing you with the best possible care.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance**, our policy is to charge a **NO SHOW FEE** for missed office appointments.

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I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for this account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

_____ X _____
Patient Name Signature Date

Ketamine Infusion Therapy Disclaimer

I wish to participate in Ketamine Infusion Therapy at Relievus. I understand and acknowledge that Ketamine Infusion Therapy may **NOT** be covered by either federal or private payors and that my personal healthcare insurance may **NOT** cover Ketamine Infusion Therapy. Thus, I agree not to make a claim for Ketamine Infusion Therapy with my personal healthcare insurance carrier and further agree and acknowledge that I must pay by cash or major credit card all related healthcare costs related to the Ketamine Infusion Therapy at Relievus.

By signing below, I accept and acknowledge that **I am opting out** of using my healthcare insurance for the Ketamine Infusion Therapy and accept paying cash or major credit card for these services.

I understand clearly that Ketamine infusion therapy is NOT FDA approved.

Acknowledged and accepted by:

Patient Name

Patient Signature Date



Ketamine Infusion Center

PRE-PROCEDURE PATIENT INSTRUCTIONS

- Come with an **empty stomach**! Do **NOT** eat (no food, no cereal, nothing) or drink anything (no water, no soda, no coffee, no tea, no Gatorade, nothing) at least **6 hours prior** to your procedure. Do **NOT** chew gum or suck on any candy/mint (no gum, no mint, no candy, no cough drops)
- Please **continue to take** your blood pressure pills, seizure medications, asthma medications, thyroid medication, pain medications as prescribed/scheduled with a sip of water.
- You should have an **ESCORT** to drive you home due to the nature of the procedure. **THIS IS MANDATORY!**
- Please arrive **30 minutes before** your appointment time. This allows us time to complete the necessary paperwork and nursing assessments prior to the procedure
- Wear loose fitting clothing the day of your procedure

Female Patients

- If you are pregnant or trying to get pregnant, you **MUST** inform us immediately.
- **Urine pregnancy test** will be done prior to the procedure at the facility.

Diabetic Patients

- If you are a **DIABETIC**, you need to let us know and we will schedule your procedure early in the morning. Take ½ of your long acting insulin the morning of your procedure only. **DO NOT** take any oral diabetic medications.
- Please, check your glucose (finger stick) at home on the procedural day.

HOME CARE INSTRUCTION AFTER THERAPY

ACTIVITY

- Take it easy today! **REST** for 24 hours. Then, increase activity as tolerated.
- **DO NOT** drive any vehicle or **DO NOT** operate any equipment for 24 hours.
- **DO NOT** make any important decision for 24 hours.

DIET & MED

- Resume normal diet as tolerated.
- Resume your medications as instructed including pain medication.

Patient's Name: _____ X _____ Date: _____

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Informed Consent for Ketamine Infusion Therapy

The label information on the container, in the package insert, in the Physician's Desk Reference (PDR) and in any advertising can indicate a drug's use only in certain "approved" doses and routes of administration for a particular condition. The use of a drug for a disease not listed on the label, or in a dose, or by a route not listed on the label is considered to be an "off- label" use of the drug. Physicians, based on their knowledge and on available current information, may use a drug for a use not indicated in the "approved" labeling if it seems reasonable or appropriate.

- I know that ketamine is NOT an FDA approved treatment for pain, depression, bipolar disorder, or PTSD.
- I know that my taking part in this procedure is my choice.
- I know that I may decide NOT to take part or to withdraw from the procedure at any time.
- I know that I can do this without penalty or loss of treatment to which I am entitled.
- I also know that the doctor may stop the infusion without my consent.
- I also know that ketamine infusion therapy may NOT help my chronic pain, depression, bipolar, or PTSD.
- I have had a chance to ask the doctor questions about this treatment.
- They have answered those questions to my satisfaction.
- The nature and possible risks of a ketamine infusion have been fully explained to me.
- The possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me.
- No guarantees or assurances have been made or given to me about the results that may be obtained

An intravenous line (IV) will be started in an extremity so you can receive ketamine. The risk of venipuncture (IV line insertion) may include temporary discomfort from the needle stick, bruising, infiltration or infection. Fainting may also occur. Your blood pressure, heart rate, and oxygen saturation will all be monitored throughout the infusion under the supervision of a physician.

Risks / Side Effects

Risk of ketamine: Side effects normally depend on the dose and how quickly the injection is given. The dose being used is lower than anesthetic doses and will be given slowly over 40-60 minutes. These side effects often go away on their own.

Common side effects

- hallucinations
- nausea and vomiting
- increased saliva production
- dizziness
- blurred vision
- increased heart rate and blood pressure during the infusion -out of body experience during the infusion
- change in motor skills
- These symptoms dissipate when the infusion is stopped. If they are severe, another medication such as a sedative can be used to treat the symptoms. You should not drive the day of an infusion and can resume driving the following day.

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Uncommon side effects

- rash
- double vision
- pain and redness in the injection site
- increased pressure in the eye
- jerky arm movements resembling a seizure
- allergic reaction
- irregular or slow heart rate
- arrhythmia (abnormal heart rhythms)
- low blood pressure
- cystitis of the bladder: inflammation, ulcers, and fibrosis
- constipation

Other Risks:

- Ketamine may cause various symptoms including but not limited to flashbacks, hallucinations, feelings of unhappiness, restlessness, anxiety, insomnia and disorientation.
- Allergic reaction from materials containing latex, Ketamine, and/or other medications or medical supplies
- Infection on skin, tissue, bones, joints, nerves, ligaments, possibly blood stream (Sepsis) and brain and may require hospitalization from medical supplies (IV catheter, IV tubing) and/or medications.
- Nausea, Vomiting and gastric contents (vomitus material) can be aspirated and can cause serious lung disease such as Aspiration Pneumonia or Aspiration Pneumonitis
- Changes in blood pressure, eye injury, peripheral nerve injury, drug reactions, cardiac arrest, strokes, heart attack, brain damage, paralysis or death
- There is a potential risk of dosing error or unknown drug interaction that may require medical intervention including intubation (putting in a breathing tube), or hospitalization.
- The risk of venipuncture may include temporary discomfort from the needle stick, bruising, infiltration or infection. Fainting may also occur.
- Risk of discomfort in answering questionnaires about your mental health and drug and alcohol use.
- Risk of other medications interacting with ketamine. It is very important that you disclose all medications, both prescription and over the counter, that you are taking.
- Ketamine may not help your depression, bipolar disorder, or PTSD

Benefits

- Ketamine has been associated with a decrease in pain, depression, bipolar, and PTSD symptoms with results lasting for days to weeks to months. There is no way to predict how any single person will respond to ketamine infusion therapy. These effects may not be long lasting and will most likely require further infusions.

Risk Management

- You must report any unusual symptoms or side effects at once to the medical staff or the physician
- On the day of the infusion, you should NOT engage in any of the following after the infusion:
 - ✓ driving
 - ✓ drinking alcohol or using drugs
 - ✓ conducting business
 - ✓ participating in activities which require you to rely on motor skills or memory

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Voluntary Nature of the Treatment

- You are free to choose to receive or not receive the ketamine infusion. Please tell the doctor if you do not wish to receive the infusion.

Withdrawal of Treatment

- Your doctor has the right to stop the infusion at any time. They can stop the infusion with or without your consent for any reason.

You have a pain problem and/or mood disorder that has not been relieved by routine treatments. Ketamine infusion therapy is now indicated for further evaluation or treatment of your pain and/or mood disorder. There is **NO** guarantee that Ketamine infusion therapy will cure your pain and/or mood disorder, and in rare cases, it could become **WORSE**, even when the infusion was completed in a technically perfect manner. The degree and duration of relief varies from person to person, so after the infusion therapy, we will reevaluate your progress, then determine if further treatment is necessary. Your physician will explain the details of the procedure listed below. Alternatives to the procedure include medications, physical therapy, psychotherapy, counseling, acupuncture, surgery, interventional treatments, etc. Benefits include increased likelihood of correct diagnosis and /or of decrease or elimination of pain or mood disorder.

The incidence of serious complications listed above requiring treatment is low, but it may still occur. Your physician believes the benefits of Ketamine Infusion Therapy outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done. I have read or had read to me the above information including the Pre-Procedure Patient Instruction page. I **UNDERSTAND** there are risks involved with the Ketamine infusion, to include rare complications, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to the Ketamine Infusion Therapy. The options, risk and benefits of the Ketamine Infusion Therapy have been discussed with me. All my questions have been answered to my full satisfaction. By signing this request form, I am indicating that I understand the contents of this document, agree to its provisions and consent to the administration of Ketamine. I am also acknowledging that the practice of anesthesiology, medicine and pain management is not an exact science and that no one has given me any promises or guarantees about the administration of Ketamine or its results. All blanks or statements requiring insertion or completion were filled in before I signed this consent and all of my questions have been answered to my satisfaction. I have been advised not to operate machinery, drive a car, and/or make important decisions for at least 24 hours after the infusion therapy.

Patient's Name: _____ X _____ Date: _____

Physician's Name: _____ X _____ Date: _____

Witness: _____ X _____ Date: _____



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Last Name: _____ First Name: _____ SEX: M F

If patient is a minor, name of parent or guardian accompanying patient: _____

Relationship to patient: _____ Phone # (if different): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ SS#: _____

(Circle one) Married Single Divorced Widowed Other

Referred by: _____ Phone: _____ Location: _____

Family Doctor: _____ Phone: _____ Location: _____

Emergency Contact: _____ Phone: _____

Are we authorized to release your medical information to the listed emergency contact? Yes or No

SIGNATURE: _____ DATE: _____



Ketamine Infusion Center

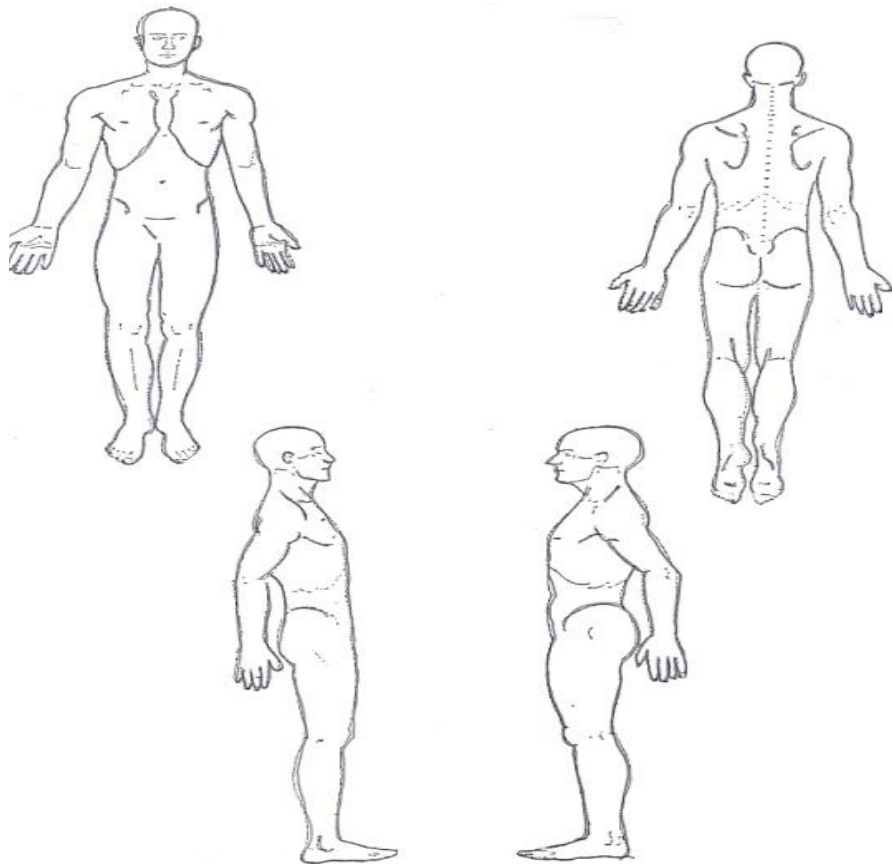
• Today's date: _____ • Name : _____

• Age _____ • Date of Birth _____ • Height _____ • Weight _____

Right hand dominant Left hand dominant • Sex : Male Female

Referral Physician: _____ **Primary Care Physician:** _____

Chief Complaints;



• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

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• Location _____

• Does the pain radiate anywhere (“shooting down” or “shooting up”)

• When was the pain started ? _____

• How was the pain started ? _____

• Please, describe your pain

Dull Aching Sharp Shooting Stabbing Throbbing Numbness Burning

• How often is your pain present ? Occasional Frequent Constant

• Worst time of day? Morning Afternoon Evening Night All the time

• Any color change or temperature change? _____

• Numbness in anywhere? _____

• “Pins and needles” ? _____

• Weakness? (Right leg, right arm, both legs....) _____

• Swelling ? _____

• What makes symptoms worse/exacerbate? _____

Walking Standing Lying down Sitting Bending forward Bending backward Driving
 Coughing Bowel movement Cold weather Hot weather Rainy day Lifting objects

• What makes the symptoms better ? _____

Resting Massage Exercise Sitting Lying down TENS unit Physical therapy

“Injections” Sleeping Medication (Names) _____ Other _____

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• Sleeping : Well "OK" Terrible 2 hrs 4 hrs 6 hrs 8 hrs >10 hrs

• How often do you wake up at night? 0 1 2 3 4 >5 times

Previous Treatments

Physical therapy Location _____ Date of Last PT _____ Duration _____

Acupuncture _____ Psychotherapy _____

Chiropractor _____ Other (Biofeedback, Meditation, Yoga, Swimming)

TENS Unit Never used I have a unit I don't have one Used at home daily Used at home as needed Used during PT

Review of System

- Gen Weight loss Weight gain Fever Fatigue Loss of appetite Nausea Vomiting
- Skin Skin problem Rash Psoriasis Slow healing Easy bruising Itching
- Neuro Light headed/dizziness Fainting Weakness Stroke Tremor Seizure Memory loss
- Eyes Vision problem Glaucoma Blurred vision Double vision
- ENT Ear pain Hearing loss Ear noises Nose bleed Sore throat Hoarseness Dental issues
- Cardiovascula Chest pain Chest pressure Shortness of breath Irregular heart beat Murmurs
- Respiratory Coughing Difficulty breathing Asthma/Wheezing Coughing up blood
- Gastrointestinal Constipation Diarrhea Heartburn Bloody stool Pain in stomach Ulcers Hepatitis
- Genitourinary Painful urination Frequent urination Bloody urine Kidney stone Incontinence
 Sexual difficulty Infection
- Endocrine Hypothyroidism Hyperthyroidism Diabetes Parathyroid problems
- Hematology Anemia Bleeding disorder Easy bleeding Lymphoma/Leukemia Sickle cell disease
- Immunologic Catch cold easily HIV/AIDS Fever Hay fever Frequent sinus problems Allergies
- Musculoskeletal Arthritis Rheumatoid arthritis Osteoarthritis Compression fracture Head injury
 Neck injury Lower back injury Spinal trauma Birth trauma Birth defect Lupus
 Spina bifida Gout Osteoporosis Muscular dystrophy Muscle pain Scoliosis
- Women only Irregular periods Premenstrual depression Hot flashes Menstrual cramps
 Vaginal discharge Hysterectomy Breast surgery Nipple discharge Breast lumps Last mammogram _____
- Men only Burning on urination Dripping after urination Prostate problems Difficulty urinating
- Psychiatric Depression Anxiety Panic attacks OCD Manic Bipolar Suicidal attempts
 Suicidal ideation Homicidal Hallucination Psychosis Other _____

Past Medical History

- Heart Coronary artery disease Hypertension Murmurs Valvular disease Aneurysm High cholesterol
 Pacemaker Deliberator Heart failure Angina Other _____
- Lungs Asthma COPD Emphysema Bronchitis TB Pneumonia Lung cancer Other _____
- Gastrointestinal Ulcer Reflux Gastritis Hepatitis Cancer Bleeding Diverticulosis Other _____
- Kidney Failure Stones Dialysis (When) _____ Other _____
- Endocrine Diabetes Hypothyroidism Hyperthyroidism Other _____
- Neuro Stroke Aneurysm Brain cancer Nerve injury Spinal cord injury Alzheimer's Dementia
 Seizures Parkinson's Other _____
- Psychiatric Depression Bipolar Anxiety Panic disorder Psychosis Schizophrenia Other _____

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- Bone/Muscular Arthritis Rheumatoid arthritis Osteoarthritis Gout Osteoporosis Scoliosis Other _____
- Cancer _____
- Other _____

Past Surgery History

Allergies

- Latex No Yes Reaction _____ • Contrast (Dye) No Yes Reaction _____
- Allergic to any medication(s) ? _____

Previous Medications (Tried previously but failed to relieve the symptoms & pain)

Current Medications

Significant Family History (Cancer, hypertension, diabetes, depression, back pain...)

- Father side _____
- Mother side _____
- Siblings _____

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Social History

- Tobacco: Never Quit in _____ Currently ____ pack per day
- Alcohol : Never Rarely Moderate Daily _____
- Use of drugs: Never Occasionally Frequently, Type/frequency _____
- Marital status: Single Married Separated Divorced Widowed

- Family status: Living with _____

- Occupation: _____

- Disability: No Yes (Type) _____

This form is completed by

Patient _____ Date _____



Ketamine Infusion Center
Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Relievus is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient’s instructions.

Entity to Receive Information Description of information to be released

Check each person/entity that you approve to receive information.

- Voice Mail
 - Results of lab tests/x-rays
 - Other _____

- Spouse (provide name & phone number) _____
 - Financial
 - Medical as follows: _____

- Parent (provide name & phone number) _____
 - Financial
 - Medical as follows: _____

- Other (provide name & phone number) _____
 - Financial
 - Medical as follows: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative’s Authority (attach necessary documentation)

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Ketamine Infusion Center

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 Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care service. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our web site www.relievus.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician’s practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when have the necessary permission from you to disclose your protected health information. For example, your protected health information is provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and Disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situation without your authorization. These situations include:

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Required By Law: We may use or disclose your protected health information to the extent that use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such or disclosures.

Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency got activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit program, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state law.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviation, tract products; to enable product recalls; to make repairs replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purpose include (1) legal processes and otherwise required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises or the practice, and (6) medical emergency (not on practice's premises) and it's likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to reasonable anticipation of death. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purpose.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state law, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Required Uses and Disclosure: Under the law, we must make disclosure to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

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You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have the decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. **You have the right to request a restriction of your protected health information.** This means you may ask us not to disclose any part of your protected health information for the purpose of treatment, payment or health operation. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by **(describe how patient may obtain a restriction.)**

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purpose. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain; restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary 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 our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____ Date _____