Evergreen Health Promotion

Patient Information Sheet

Date_______________

Name (last) ______________________________ (first) ________________________________ (initial)
______

Birthdate ___________________ Social Security Number______________________________

Address____

City____________________________________ State_____________ Zip___________________

Sex: M__ F__

Email____

Home Phone__________________________ Cell Phone_____________________________

Emergency Contact______________________________________ Phone______________________

Employer____

Occupation____

Insurance Carrier____

Self Pay______

There may be instances that your health care provider may wish to communicate some aspects of your protected health information and or account information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Evergreen Health Promotion cannot guarantee privacy for communications over the internet. I understand and accept this risk, and will allow Evergreen Health Promotion to communicate my information electronically. YES___ NO___

By my signature below, I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Evergreen Health Promotion to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party______________________________________ Date_______________

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.____			
2.____			
3.____			
4.____			

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:____	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Occupation ____________________

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? ______

Alcohol Do you drink alcohol? ☐ Yes ☐ No
If so, how often? ☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco? ☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes - _____pks./day
☐ Chew - _____/day
☐ Cigars - _____/day
☐ # of years_____
Or year quit __________

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list: ____________________

FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: ______________________________

Other concerns: ______________________________

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY

____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Chickenpox Date: __________
- ☐ Flu Shot Date: __________
- ☐ Gardasil/HPV Date: __________
- ☐ Hepatitis A Date: __________
- ☐ Hepatitis B Date: __________
- ☐ Meningococcus Date: __________
- ☐ MMR (*Measles, Mumps, Rubella*) Date: __________
- ☐ Pneumonia Date: __________
- ☐ Tdap (*Tetanus and pertussis*) Date: __________
- ☐ Tetanus Date: __________
- ☐ Zostavax (*Shingles*) Date: __________

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date __________ ☐ Abnormal

Last Mammogram Date __________ ☐ Abnormal

Age of first menstrual period: ______

Date of last menstrual period or age of menopause: __________

Number of pregnancies: ______ births: ______

miscarriages: ______ abortions: ______

☐ Cesarean sections If yes, then number: ______

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
  - Current sexual partner is ☐ Female ☐ Male
  - Do you use condoms? ☐ Yes ☐ No
  - Other Birth control method used: __________
  - ☐ Interested in being screened for STD's

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_________

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

____

____

____

____

______________________________ ______________________

Parent, Guardian, or Caregiver Signature Date

Dr. Robert L. Bloomfield, M.D., M.S., Director

ACKNOWLEDGEMENT OF RECEIPT
OF
PRIVACY PRACTICE NOTICE

I acknowledge that I was provided a copy of the Privacy Practice Notice and that I read (or had the opportunity to read) and I understand the Notice.

____
Patient Name (Print)

____
Parent or Authorized Representatives (if applicable)

____
Signature

____
Date

Evergreen Health Promotion
1365 Westgate Center Dr., Suite G # 1
Winston Salem, NC 27103

Dr. Robert L. Bloomfield, M.D., M.S., Director

AUTHORIZED USE OF MEDICAL INFORMATION

Uses and Disclosures Based On Your Written Authorization: These uses and disclosures of your protected health information will be made only with your written authorization.

You may give us written authorization to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in affect. Without your written authorization, we will not disclose your health care information except as described in the Notice of Privacy Practices.

I, ______________________________, hereby authorize ____________________ ,
To receive any and all of my health care information. ***(Spouse or Family Member)***

____
Signature

____
Date

____
Witness

Evergreen Health Promotion
1365 Westgate Center Dr., Suite G # 1
Winston Salem, NC 27103

The Philosophy of Evergreen Healthcare

- Our practice is built on personal patient responsibility. We are a partnership between patients, practitioners, nurses and others.
- Equal respect *must* be given to each and every member of our team.
- Insured, underinsured, and non-insured people may be accepted, depending on circumstances and motivations.
- We need to collect reimbursement in order to treat individuals, keep our practice open, and be available for all our patients. Insurance companies require that we collect your co-pay before you're seen [if insured].
- Not everyone will fit into our practice routines. If navigating the healthcare system along with your help, cooperation, support, politeness, lifestyle changes, proper medication, etc. becomes too costly, difficult, or time-consuming for us, we reserve the right to stop our partnership with you. In that event, we will help you in trying to find alternative healthcare.
- There may be occasional interim visits for dietary/supplemental visits. One of our goals is not only to prevent illness, but also to improve your overall health, and keep you out of the hospital, emergency room, or urgent care facility, please try and call us first before going to one of these facilities. We may be able to speed your visit or help you avoid long waits, unnecessary visits, etc., especially if you don't have a life-threatening illness or if your problem occurs during our regular working hours.
- Very few disability claims are accepted, though we are willing to review and assess them for the cost of an office visit. Our main emphasis is to make you more functional, more mobile, and to rely less on disability and/or dependency-producing medication.
- We discourage a sense of entitlement. You should be actively improving your health situation and not waiting on a physician or outside institution to make things tolerable for you. Stay active. Stay involved. Use or develop a social network.
- We spend an extended amount of time on health education.
- We expect patients to keep their appointments. A 12-hour notice is required for cancelled appointments; otherwise, there will be a $30 charge added to your bill.
- If you need the price of your medications lowered, it will entail a special office visit.
- Please bring all medications, vitamins, and supplements to each visit; and your insurance card and medication formulary book also.

Forms and Financial Responsibility

As a patient of Evergreen Health Promotion you will be required to sign a financial responsibility and authorization for treatment form.

On occasion your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

- Not a Covered Benefit - is not covered or only partially covered by your insurance plan, also excluded may be work injury or auto accidents.
- Not deemed medically necessary - not provided as the result of illness or injury.
- Before or after Eligibility - services provided during a period your policy is not in effect.

Co-pay Requirements

It is the policy of the Evergreen Health Promotion that patients are prepared to pay their required copayment at the time service is rendered.

Self-Payment or Self-Pay

Evergreen Health Promotion requires full payment at the time service is rendered. However, certain circumstances where the patient is financially unable to pay full amount, a payment plan will be considered.

Self Pay Financial Policy

- All cash patients and patients that present without valid insurance information are considered a Self-Pay Patient.
- All Self-Pay patients are required to pay at the time service is rendered.
- Please be prepared to make this payment with the front desk personnel after the visit.
- You will be requested to fax or provide copy of the front and back of your insurance card for our records. You can fax your insurance information to (336)659-6239.

Forms of Payment

We accept Cash, Checks, Visa, Master Card and American Express.

Patient Signature____

Thank you,

Dr. Robert Bloomfield

Medication Log

Name: ______________________ Birthdate: ____________ Med Allergy: ______________________

Pharmacy: ______________________ Pharmacy Phone/Fax: ______________ / ______________

Date	Med. & Strength	Directions & Quantity	Refill #1	Refill #2	Refill #3	Refill #4	Presc. By

EverGreen Health Promotion

The Office of Dr. Robert Bloomfield

Allergy Form

During our transition to Electronic Health Records, we have a come across a problem transcribing your allergy information. Please help us with this transition by listing all of your current allergies along with the reactions you have to the specific allergen. We are unable to record the information unless the reaction is provided. If you were tested for an allergy and you do not know the reaction, please write that you were tested for said allergy. We thank you for your assistance during this cumbersome transition.

Allergy	Reaction

NOTICE OF PRIVACY PRACTICES OF

EvergreenHealth Promotion

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.

A. WE MUST PROTECT HEALTH INFORMATION ABOUT YOU.

We are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

We must protect PHI that we have created or received about: your past, present, or future health condition; health care we provide to you; or payment for your health care.

We must notify you about how we protect PHI about you.

We must explain how, when and why we use and/or disclose PHI about you.

We may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures which occur as a byproduct of the permitted uses and disclosures described in this Notice.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

Posting the revised notice in our offices; making copies of the revised notice available upon request (either at our offices or through the contact person listed in this Notice); and posting the revised notice on our website www.digestivehealth.ws

B. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR PERMISSION IN THE FOLLOING CIRCUMSTANCES.

1. We may use and disclose PHI about you to provide health care treatment to you.

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

EXAMPLE: Your doctor may share medical information about you with another health care provider. For example, if you are referred to another doctor, that doctor will need to know if you are allergic to any medications. Similarly, your doctor may share PHI about you with a pharmacy when calling in a prescription or with a laboratory when ordering lab tests.

2. We may use and disclose PHI about you to obtain payment for services.

Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of medical information about you with the following:

- Billing departments;
- Collection departments or agencies, or attorneys assisting us with collections;
- Insurance companies, health plans and their agents which provide you coverage;
- Hospital departments that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and
- Consumer reporting agencies (e.g. credit bureaus).

EXAMPLE: Let's say you have been referred to us for a colonoscopy. We may need to give your health plan(s) information about your condition, for any required pre-authorization, to the hospital where the colonoscopy will be performed and to pathologists, radiologists or other medical professionals that may need to bill you for services they may provide as a result of your colonoscopy. This information is given to our billing department and your health plan so we can be paid or you can be reimbursed. We may also send the same information to any hospital department which reviews our care of your illness or injury.

3. We may use and disclose PHI about you for health care operations.

We may use and disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. We may also disclose PHI for the "health care operations" of any "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the care provided by a hospital and the physicians who see patients at the hospital. In addition, we may disclose PHI about you for the "health care operations" of other providers involved in your care to improve the quality, efficiency and costs of their care or to evaluate and improve the performance of their providers. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients. For example, we may use PHI about you to develop ways to assist our health care providers and staff in deciding what medical treatment should be provided to others.

Improving health care and lowering costs for groups of people who have similar health problems and to help manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives, classes, or new procedures.

Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.

Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.

Cooperating with outside organizations that assess the quality of the care we and others provide. These organizations might include government agencies or accrediting bodies.

Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.

Assisting various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with applicable laws.

Conducting business management and general administrative activities related to our organization and the services it provides.

Resolving grievances within our organization.

Reviewing activities and using or disclosing PHI in the event that we sell our business, property or give control of our business or property to someone else.

Complying with this Notice and with applicable laws.

4. We may use and disclose PHI in other situations without your permission.

We may use and/or disclose PHI about you without your permission in situations when the use and/or disclosure:

is required by law.
is necessary for public health activities.
relates to victims of abuse, neglect or domestic violence.
is for health oversight activities.
is for judicial and administrative proceedings.
is for police or other law enforcement purposes.
relates to a person who has died.
relates to organ, eye or tissue donation purposes.
relates to medical research in certain limited situations.
is to prevent a serious threat to health or safety.
relates to specialized government functions.
relates to inmates of correctional institutions and in other law enforcement custodial situations.

5. You can object to certain uses and disclosures.

Unless you tell us not to, we may use or disclose PHI about you in the following circumstances:

We may share your name and your general condition (critical, serious, etc.) with clergy and with people who ask for you by name.

We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. We also may notify such individuals of your location, general condition or death.

We may share with a public or private agency (for example, American Red Cross) PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary for the emergency circumstances.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please tell the front desk person who registered you or contact our Privacy Official listed on the cover page of this Notice.

6. We may contact you to provide appointment reminders.

We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

7. We may contact you with information about treatment, services, products or health care providers.

We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.

EXAMPLE: If you are diagnosed with celiac disease, we may tell you about nutritional and other counseling services that may be of interest to you.

**** ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION ****

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. We will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

C. YOU HAVE SEVERAL RIGHTS REGARDING YOUR PHI.

1. You have the right to request restrictions on uses and disclosures of PHI about you.

You have the right to request that we restrict the use and disclosure ofyour PHI. You must ask us in writing. We are not required to agree to your requested restrictions. Even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection B.4 of the previous section of this Notice. You may request a restriction by filling out a form that you can obtain from our front desk personnel. Your request will be granted unless we tell you otherwise in writing.

2. You have the right to request different ways to communicate with you.

You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number instead contacting you at home. Your request must be in writing. We will accommodate all reasonable requests, if we can. In order for us to do this, you must provide us with information regarding how payment, if any, will be handled. You must also provide us with an alternative address or other method of contact. You may request alternative communication by completing an alternate communication form available from our front desk personnel.

3. You have the right to see and copy PHI about you.

You have the right to inspect and obtain copies of your PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may contact our front desk personnel for request forms.

4. You have the right to request amendment of PHI about you.

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you that you believe are incorrect or incomplete. Your request must be in writing and must explain why you want us to make the change. We do have to make the change if: 1) the information was not created by us (unless the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. You may request an amendment of PHI by completing the Medical Record Amendment/Correction form available from our front desk personnel.

5. You have the right to a listing of non-routine disclosures we have made.

You have the right to request an "accounting of disclosures." This is a list of the non-routine disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. You must submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of disclosures by completing a disclosures request form available from our front desk personnel.

6. You have the right to a copy of this Notice.

You have the right to request a paper copy of this Notice at any time. You may contact any of our front desk personnel or Peter S. Donaldson, Privacy Official for Digestive Health Specialists, 2025 Frontis Plaza Blvd, Suite 200, Winston-Salem, NC 27103, 336-768-6211. In addition, this notice is posted on our web site www.digestivehealth.ws and in our office. We will provide you with a copy of this notice for you to review when you arrive for your first office visit.

D. YOU MAY HAVE ADDITIONAL RIGHTS UNDER OTHER LAWS.

Some North Carolina laws give greater protection of privacy than federal laws. We must follow both federal and state law. These North Carolina laws may apply to our treatment of you:

North Carolina law protects not only your rights of privacy, but also your relationship with your physician. State law generally restricts disclosure of your health information in most instances. However, we may disclose health information about you under State law with your permission, pursuant to a court order, or as otherwise may be permitted or required by law. In instances in which your permission is required, we will request that you sign a consent form (which is different than an authorization that is mentioned in other parts of this Notice).

If you ask for treatment and rehabilitation for drug abuse, your request will be confidential. We will not give your name to any police officer or other law-enforcement officer unless you give us permission to do so. If we refer you to another person for help, we will continue to keep your name confidential.

If you have a communicable disease (for example, tuberculosis, hepatitis or HIV/AIDS), information about your disease will be kept confidential, and only will be shared without your written permission in limited situations. For example, we will get your permission to share this information for payment purposes. We do not need to get your permission to report information about your disease to State and local health officials or to prevent the spread of the disease.

E. YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES.

If you think we have violated your privacy rights, or you want to complain to us about our privacy practices, you can contact **Peter S. Donaldson, Privacy Official, 336-768-6211.** You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

F. EFFECTIVE DATE OF THIS NOTICE: This Notice of Privacy Practices is effective on April 14, 2003.