McCulloh Therapeutic Solutions

New Patient Intake Form

Please help us serve you better by taking a few minutes to complete the information below.

Patient Information

Patient's First Name	Middle Name	Last Name	Suffix
Street Address	City	State	Zip Code
Date of Birth (MM/DD/YYYY)		Gender (M/F)	
Social Security Number		Primary Phone Number	
Patient's Relationship to Insurance Plan Holder		Patient's Email Address (If Applicable)	
Referring Physician's Name/Practice Name		Referring Physician's Phone Number	
Name of Person Completing This Form & Relationship to Patient			

Patient's Mother's Name	Mother's Primary Email Address
Mother's Home Phone Number	Mother's Cell Phone Number
Mother's Primary Mailing Address (If Different From Above)	

Patient's Father's Name	Father's Primary Email Address
Father's Home Phone Number	Father's Cell Phone Number
Father's Primary Mailing Address (If Different From Above)	

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Parent/Guardian/Caregiver Information

Title First Name Middle Name Last Name Suffix

Street Address (If Different from Above) City State Zip Code

Date of Birth (MM/DD/YYYY) Gender (M/F)

Social Security Number Email Address (If Different From Above)

Home Phone Number Cell Phone Number

Relationship to Patient (Parent, Guardian, Other) Student (F- Full Time; P- Part TIme; N- None)

Marital Status (S- Single; M- Married; D- Divorced; W- Widowed; X- Separated)

Employment Status (F- Full Time; P- Part Time; R- Retired; N- None)

Employer Name (If Applicable)

Employer Street Address City State Zip Code

Business Phone Number

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Primary Insurance Information

First Name (of Insurance Plan Holder) | Middle Initial | Last Name | Suffix

Street Address (If Different From Above) | City | State | Zip Code

Home Phone Number (If Different From Above) | Cell Phone Number (If Different From Above)

Insurance Provider Name | Policy/Account/Plan Number

Insurance Provider Phone Number | Group Number

Secondary Insurance Information

First Name (of Insurance Plan Holder) | Middle Initial | Last Name | Suffix

Street Address (If Different From Above) | City | State | Zip Code

Home Phone Number (If Different From Above) | Cell Phone Number (If Different From Above)

Insurance Provider Name | Policy/Account/Plan Number

Insurance Provider Phone Number | Group Number

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Tertiary Insurance Information

First Name (of Insurance Plan Holder) | Middle Initial | Last Name | Suffix

Street Address (If Different From Above) | City | State | Zip Code

Home Phone Number (If Different From Above) | Cell Phone Number (If Different From Above)

Insurance Provider Name | Policy/Account/Plan Number

Insurance Provider Phone Number | Group Number

By signing this document, I confirm that I have filled out this document with information that is complete, true and correct to the best of my ability and knowledge. I also authorize the release of any medical and/or other information necessary to process insurance claims, and I authorize payment of medical benefits directly to MCCULLOH THERAPEUTIC SOLUTIONS for services rendered.

Patient's Printed Name | **Date**

Parent/Guardian/Caregiver's Printed Name | **Parent/Guardian/Caregiver'sSignature**

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Patient Case History

MEDICAL & SOCIAL HISTORY:

Patient's Primary Pediatrician (Physician & Practice Name - If Different from Referring Physician)

Pediatrician's Phone | Pediatrician's Fax Number

Patient's Early Interventionist (Provider Name - If Applicable)

Early Interventionist's Phone | Early Interventionist's Fax | Early Interventionist's Email

Current Services Provided (ST, OT, PT, EI, etc.) | Location/Frequency of Current Services

Patient's Birth Weight (lbs./oz.) | Birth Type (V- Vaginal; C- C-Section)

Was the patient born prematurely? (If yes, how early?)

Please list the names and relationship to patient of all individuals living in the patient's home. If patient has any siblings, please include siblings' dates of birth.

Were there complications during pregnancy and/or labor? If yes, please describe.

Were there any medications taken during pregnancy and/or labor? If yes, please describe/list medications.

Was the patient required to spend time in the hospital's NICU? If yes, please explain.

Does the patient currently take any medications? If yes, please describe/list medications.

Does the patient currently have any allergies? If yes, please describe/list allergies.

Does the patient have a current diagnosis and/or syndrome? If yes, please describe.

Does the patient have a history of ear infections? If yes, has the patient's hearing been checked? Have PE tubes been placed?

Has the patient had any surgeries and/or significant illnesses? If yes, please explain.

Does the patient currently attend daycare/preschool/school? If yes, please disclose location, frequency of attendance and the patient's teacher.

Does the patient currently have any hearing concerns or difficulties? If yes, please explain.

Does the patient currently have any vision concerns or difficulties? If yes, please explain.

Does the patient currently have any sleeping concerns or difficulties? If yes, please explain.

PEDIATRIC SPEECH/LANGUAGE/FEEDING HISTORY:

What are the patient's primary Speech/Language/Feeding concerns?

When was the problem first identified? Please describe.

SPEECH DEVELOPMENT:

Please list any sounds the patient has difficulty producing.

Does the patient demonstrate any stuttering behaviors and/or difficulty getting out their thoughts? If yes, please describe/explain details.

EXPRESSIVE LANGUAGE:

How does the patient communicate with you and/or others (i.e., tantrums, pulling, pointing, signs/gestures, pictures, augmentative communication, words, phrases, sentences, etc.)?

In what situation(s) is it most difficult for the patient to communicate?

Has the patient ever used sign language, devices, or pictures to communicate? If yes, please describe.

MOTOR DEVELOPMENT: To the best of your ability, please give the approximate age (in months) when the patient was first able to do the following activities:

Activity:	Patient's Age (In Months):
Sitting Alone	
Crawling	
Standing Alone	
Walking	
Toilet Trained	
Tricycling	
Dressing Self	
Bicycling	
Walking Up Stairs	
Running	
Single Words	
Combined Words	

RECEPTIVE LANGUAGE: Please check the appropriate box(es) and comment as necessary.

Is the patient able to:	Yes	No	Additional Comments
Follow simple directions?			
Follow complex directions?			
Identify and name colors & shapes?			
Identify and name animals?			
Identify and name numbers & letters?			
Read simple words?			
Read age-appropriate sentences?			
Understand concepts (i.e., “big,” “short,” “hot,” “sleepy,” “empty”?			
Name and sort items in categories (i.e., food, clothing, animals, etc.)?			

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Pediatric Feeding Evaluation

ORAL MOTOR/FEEDING ASSESSMENT: ***Please complete the following section regarding oral motor/feeding ONLY IF you have concerns regarding the patient's oral movements and/or their ability to eat.***

Note: On the day of your appointment, please bring at least two foods (one the patient will eat and one the patient will likely refuse) and one drink in a preferred bottle or cup. Please also pack utensils and plates/dishes. It will be ideal for the patient to arrive to the appointment hungry.

1. Please check any and all of the following that apply to the patient (past or present):
   - ❑ Respiration Difficulties
   - ❑ Feeding Tube
   - ❑ Constipation
   - ❑ Diarrhea
   - ❑ Allergies
   - ❑ Muscle Weakness
   - ❑ Increased Gag Reflex
   - ❑ Decreased Gag Reflex
   - ❑ Mouth Breathing
   - ❑ Seizures
   - ❑ Frequent Colds
   - ❑ Pneumonia
   - ❑ Constant Drooling
   - ❑ Crying at Meal Time
   - ❑ Frequent Ear Infections
   - ❑ Tonsillitis
   - ❑ Reflux
   - ❑ Latex Allergy
   - ❑ Choking
   - ❑ Difficulty Latching
   - ❑ Poor Sleeping Patterns
2. Is there any family history of feeding difficulties/disorders? If yes, please explain:

   _____

   _____
3. Age of feeding difficulty onset (for patient):

   _____
4. Has the patient ever been hospitalized for feeding concerns? If yes, please explain:

   _____

   _____

5. Please list daily schedule for patient's feedings/meals:

Time	Activity and/or Feeding Type

6. Please list the patient's preferred foods (foods the patient enjoys):

_____

_____

7. Please list desired foods (foods the parent/guardian would like the patient to eat/enjoy):

_____

_____

8. Please describe the patient's behaviors when non-preferred foods are presented:

_____

_____

9. Has the patient had a Modified Barium Swallow Study completed in the last 6 months? If yes, please describe the results and/or attach a copy.

_____

_____

_____

10. Has the patient ever received VitalStim© Therapy? If yes, please explain.

_____

_____

_____

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Attendance Policy

ATTENDANCE POLICY: Please read the following carefully in regards to MCCULLOH THERAPEUTIC SOLUTIONS' Attendance Policy.

1. Treatment Location Standards:
    a. In order to respect the privacy of our patients and their treatment sessions, please do not allow children to leave the assigned areas of play and/or to excessively access the restroom area(s).
    b. Caregivers are required to stay on the premises during treatment unless otherwise approved by the patient's therapist.
    c. Caregivers who are approved to leave the premises are required to return 15 minutes before the end of the patient's session. If caregivers abuse this policy, they will be required to stay on the premises for all future sessions.
2. Tardiness, Absences and/or Cancellations:
    a. Please be courteous and respectful of MCCULLOH THERAPEUTIC SOLUTIONS staff members and other patients; please cancel therapy if the patient has presented with any of the following within 24 hours of his/her appointment: fever, diarrhea, vomiting, or any other contagious illness.
    b. In the event of excessive tardiness, absences, and/or cancellations of therapy appointments, the following procedures may occur:
        i. A conference will be held between a MCCULLOH THERAPEUTIC SOLUTIONS representative (Therapist, Division Director, Intake Coordinator, etc.) and the caregiver.
        ii. If the patient is tardy to the scheduled appointment by 20 minutes (or more), the therapist is not required to treat the patient for that appointment.
        iii. If the patient's regular attendance falls below 75% (meaning the patient is absent for more than 1 out of 4 consecutive services and has not rescheduled and/or made up the missed appointment within two weeks), the patient will be considered in violation of this attendance policy.
        iv. If compliance continues to be a problem and/or the patient is considered in violation of this attendance policy, the patient will be discharged from services.

I have read the above and hereby agree to abide by these policies and procedures. I understand that failure to adhere to the policies and procedures listed above will result in termination of services at MCCULLOH THERAPEUTIC SOLUTIONS.

Patient's Printed Name **Date**

Parent/Guardian/Caregiver's Printed Name **Parent/Guardian/Caregiver'sSignature**

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Consent To Treat & Release of Information

CONSENT FOR TREATMENT:

I, the undersigned, do hereby agree and give my consent for MCCULLOH THERAPEUTIC SOLUTIONS to furnish medical care and treatment considered necessary and proper in diagnosing or treating the patient's physical and mental condition.

Patient's Printed Name **Date**

Parent/Guardian/Caregiver's Printed Name **Parent/Guardian/Caregiver'sSignature**

CONSENT FOR RELEASE OF INFORMATION FOR MARKETING PURPOSES:

To assist in the promotion and documentation of our services, MCCULLOH THERAPEUTIC SOLUTIONS requests permission to photograph you and/or the patient. This photograph may be used, along with your/the patient's name and testimonial, in printed form on display in our clinics, in printed form for marketing and promotions, on display during promotional events around the country, in digital form on educational CDs, in our newsletter, on social media, and/or on the MCCULLOH THERAPEUTIC SOLUTIONS website.

- I give MCCULLOH THERAPEUTIC SOLUTIONS permission to use my name and/or the patient's name in marketing and/or promotional purposes.

  First Name(s) Only: **Initial _____**

  Both First and Last Name(s) **Initial _____**

- I give MCCULLOH THERAPEUTIC SOLUTIONS permission to use my photograph and/or the patient's photograph for marketing and/or promotional purposes.

  Initial _____

By signing this form, I give MCCULLOH THERAPEUTIC SOLUTIONS permission to use and disclose the patient's protected health information in accordance with the directive listed above. **You have the right to refuse to sign this AUTHORIZATION regarding release of information for marketing and promotional purposes. If you refuse to sign this AUTHORIZATION, MCCULLOH THERAPEUTIC SOLUTIONS will not refuse to provide treatment to the patient.**

Patient's Printed Name **Date**

Parent/Guardian/Caregiver's Printed Name **Parent/Guardian/Caregiver'sSignature**

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Insurance Policy & Benefit Assignment(s)

BENEFIT ASSIGNMENT & RELEASE OF INFORMATION:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to MCCULLOH THERAPEUTIC SOLUTIONS. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

By signing this form, I give MCCULLOH THERAPEUTIC SOLUTIONS permission to provide health-related services to the patient, and I request that payment of Medicaid or other third party insurance benefits be made on my behalf to MCCULLOH THERAPEUTIC SOLUTIONS for any services provided to the patient.

I understand that for any period of time when the patient is eligible for Medicaid or its related programs (Healthy Connections, Partners for Healthy Children, First Choice/Select Health, PEP, WellCare, BlueChoice, and/or other programs that may be developed), MCCULLOH THERAPEUTIC SOLUTIONS may bill the Medicaid program for those services and Medicaid may pay MCCULLOH THERAPEUTIC SOLUTIONS for providing those services. MCCULLOH THERAPEUTIC SOLUTIONS has permission to bill Medicaid retroactively for services performed prior to the date of this consent. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) and regulations pursuant thereto (45 C.F.R Part 80), upon notification and/or request of the patient's parent or guardian, McCulloh Therapeutic Solutions will take steps to ensure that Medicaid members with limited English skills receive at no cost to the member, the language assistance necessary to afford them meaningful and equal access to the Medicaid benefits and services to which they are entitled.

If the patient is not eligible for Medicaid services under South Carolina Medicaid on the date of service, reimbursement for all services provided must be resolved between the provider (MCCULLOH THERAPEUTIC SOLUTIONS) and the payee/responsible party for the patient receiving services. Providers are not required to accept Medicaid for services provided during the patient's retroactive eligibility period and may continue to bill the patient for those services. Providers may choose to accept Medicaid for the services provided during the patient's retroactive eligibility period; however, it may not extend a 60-day period. MCCULLOH THERAPEUTIC SOLUTIONS will honor retroactive eligibility up to 60 days from the date of initial Medicaid eligibility.

By signing this form, I also give MCCULLOH THERAPEUTIC SOLUTIONS permission to release or exchange medical or other information as necessary to the insurance providers, including the Medicaid program and its agents, as needed, for treatment, payment, other health-care related administration, determination of benefits, processing claims, or auditing of benefits for those services.

Patient's Printed Name **Date**

Patient's DOB (MM/DD/YYYY) | Patient's SSN | Patient's Medicaid State ID # (If Applicable)

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Parent/Guardian/Caregiver's Printed Name **Parent/Guardian/Caregiver's Signature**

Payment & Remit Policy

FINANCIAL POLICY STATEMENT:

McCulloh Therapeutic Solutions bills your insurance provider solely as a courtesy to you. You are responsible for verifying insurance coverage and eligibility with your insurance company. This includes, but is not limited to, in-network and out-of-network verification, coverage plan/policies, etc. You are responsible for the entire invoice from MCCULLOH THERAPEUTIC SOLUTIONS when the services are rendered.

MCCULLOH THERAPEUTIC SOLUTIONS requires that arrangements for payment of your estimated share be made at the time of service. **If your insurance provider does not remit payment within 60 days, the balance will be due IN FULL from you upon receipt of invoice.** In the event that your insurance provider requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance provider. In the event your insurance provider establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by MCCULLOH THERAPEUTIC SOLUTIONS, you recognize an obligation to promptly remit the same to MCCULLOH THERAPEUTIC SOLUTIONS within 15 business days. In the event that your insurance provider denies payment of services rendered by MCCULLOH THERAPEUTIC SOLUTIONS, you are required to submit all Explanations of Benefits (EOBs) to MCCULLOH THERAPEUTIC SOLUTIONS upon receipt from your insurance provider within 30 days. Failure to submit EOBs within 30 days of receipt will result in responsibility of payment transferring from the insurance provider to you directly.

When you pay by credit/debit card or check, you hereby expressly authorize MCCULLOH THERAPEUTIC SOLUTIONS to transfer funds from your account upon receipt of payment. If your check is dishonored or returned for any reason, you automatically authorize MCCULLOH THERAPEUTIC SOLUTIONS to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax).

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and understood and/or has been explained to me. **I UNDERSTAND THE POLICY AND MY RESPONSIBILITIES IN REGARDS TO THE PAYMENT OF MY ACCOUNT TO MCCULLOH THERAPEUTIC SOLUTIONS. I UNDERSTAND THAT FAILURE TO ADHERE TO THE POLICY ABOVE WILL RESULT IN TERMINATION OF SERVICES AT MCCULLOH THERAPEUTIC SOLUTIONS.**

Parent/Guardian/Caregiver's Printed Name	**Date**
Parent/Guardian/Caregiver's Signature	**Date**
MTS Representative/Witness Printed Name	**Date**

MTS Representative/Witness Signature **Date**

McCulloh Therapeutic Solutions

Patient Bill of Rights & Privacy Practices

PATIENT BILL OF RIGHTS:

The patient has the right to:

1. Be treated with dignity and privacy
2. Refuse treatment
3. Appropriate, considerate and respectful care (NOTE: Per MCCULLOH THERAPEUTIC SOLUTIONS' cell phone policy, cell phones are to be used for EMERGENCIES ONLY during therapy treatment.)
4. Receive information necessary to give informed consent prior to the start of any procedure, service or treatment
5. Receive a timely response to a request for service
6. Treatment by qualified personnel who are experienced at the level of skills needed
7. Reasonable continuity of care
8. Be given reasonable notice of anticipated termination of service or plans to transfer to another provider
9. Discuss problems and suggest changes in goals or care plan without fear of discrimination
10. Be fully informed of the policies, procedures, charges and payments required regarding services at MCCULLOH THERAPEUTIC SOLUTIONS
11. Honest, accurate, forthright information regarding outpatient rehabilitation services in general and at MCCULLOH THERAPEUTIC SOLUTIONS in particular

HIPAA Notice of Privacy Practices:

1. This notice (attached below) describes how health information about you may be used and disclosed and how you can get access to this information.
2. This notice (attached below) is posted in the office for you to read. If you need a copy for your records or have any questions about this notice, please contact MCCULLOH THERAPEUTIC SOLUTIONS at one of the following Clinic locations:
    a. Spartanburg Clinic: 864-576-7188 (P) or 864-576-8909 (F)
    b. Greenville Clinic: 864-244-3474 (P) or 864-244-3475 (F)

I have been informed of my right as a patient and/or Parent/Guardian/Caregiver of MCCULLOH THERAPEUTIC SOLUTIONS and understand the HIPAA Notice of Privacy Practices.

Parent/Guardian/Caregiver's Printed Name **Date**

Parent/Guardian/Caregiver's Signature **Date**

McCulloh Therapeutic Solutions

HIPAA NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES: As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you (as a patient of MCCULLOH THERAPEUTIC SOLUTIONS) may be used and disclosed and how you can get access to your health information. Please review this notice carefully.

Your Information. Your Rights. Our Responsibilities.
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.

LAYERED SUMMARY TEXT –

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.