Grand Rapids Women's Health

Welcome to Grand Rapids Women's Health!

We welcome you as our patient and appreciate the opportunity to provide medical care to you. Thank you for entrusting us. We look forward to serving you and providing you with an exceptional experience. We are committed to providing the highest standard of care.

Appointment Date: _____ Time: _____ Provider: _____

If you are new to our practice or it has been more than 3 years since we've last seen you, we need to collect or update your registration and medical history.

THIS PACKET IS VERY IMPORTANT FOR YOUR APPOINTMENT.

PLEASE COMPLETE THE FORMS AND BRING THEM WITH YOU.

PLEASE ARRIVE AT LEAST 15 MINUTES EARLY FOR YOUR APPOINTMENT.
PLEASE BRING YOUR INSURANCE CARD AND PHOTO IDENTIFICATION.

1. **TRANSFERRING MEDICAL RECORDS:** If you are transferring to our office, please have your records sent to the office before the first appointment. It is most helpful to have recent lab work, GYN operative reports, pathology, pap smears or anything that may be relevant to our care for you. Our mailing address or fax number is listed below.

2. **Hours, Location and Parking:** Our office is open Monday through Friday from 8:00am to 5:00pm. Our office is located at 555 Mid Towne NE, 4th Floor. Parking is provided in the ramp east of the building. Please bring your ticket to your appointment, for validation.

If you need to cancel or change your appointment(s), kindly provide at least 24 hours' notice. Without notice, a $25.00 same day cancellation or no-show fee may apply.

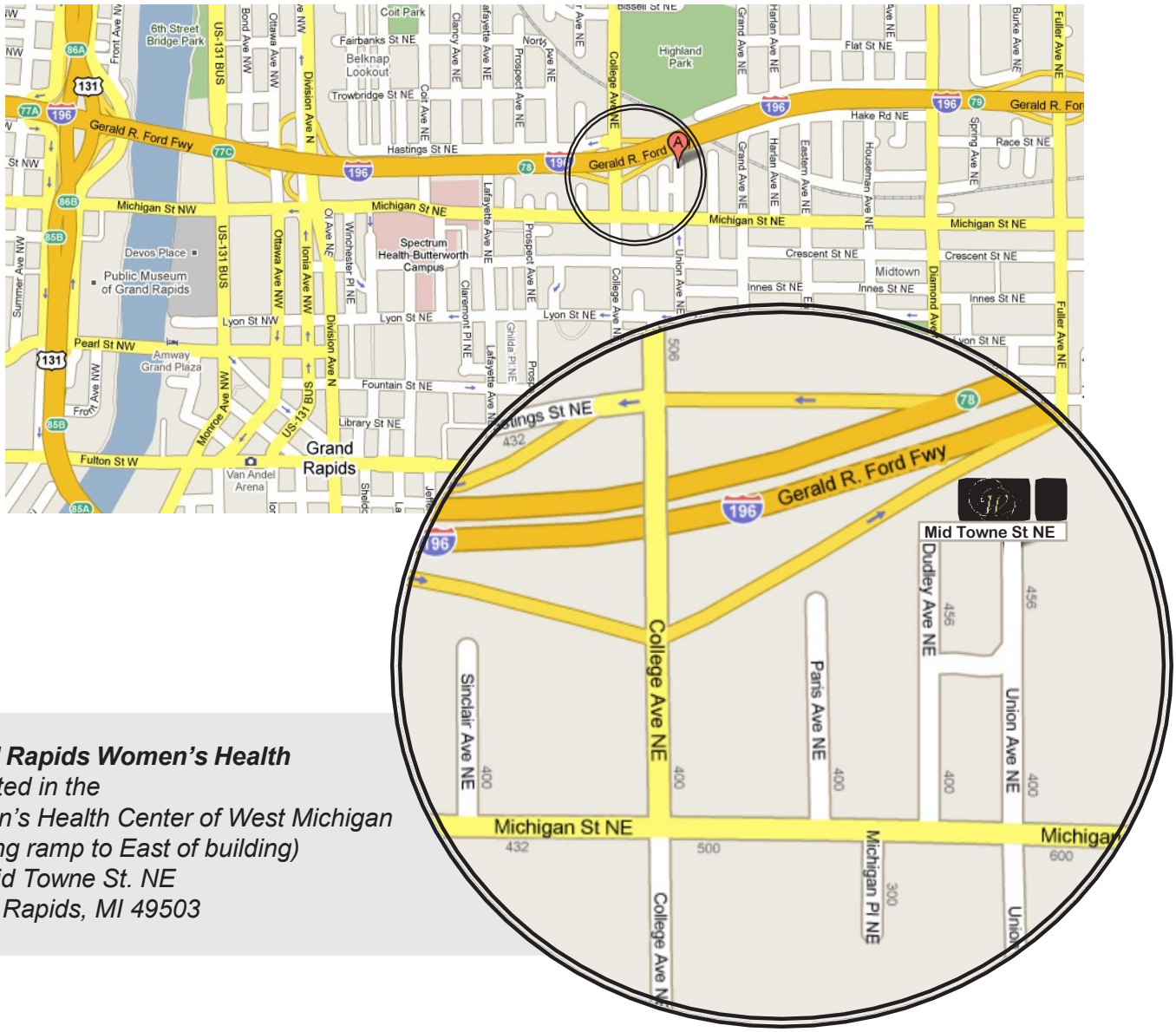
For more information about our practice or providers, please visit our website at www.grandrapidswomenshealth.com.

GRAND RAPIDS WOMEN'S HEALTH
555 Mid Towne NE Suite 400
Grand Rapids, MI 49503
Phone: 616-588-1200
Fax: 616-588-1250

Grand Rapids Women's Health

Directions: Near Michigan and College

Take 196 FWY to College Ave., travel 1 block South and turn left on Michigan St. Turn left at the next light on Union Ave. to the new Women's Health Center of West Michigan on Mid Towne Street.



Grand Rapids Women's Health
is located in the
Women's Health Center of West Michigan
(Parking ramp to East of building)
555 Mid Towne St. NE
Grand Rapids, MI 49503

Grand Rapids Women's Health
555 MidTowne St. NE Suite 400
Grand Rapids, MI 49503
616-588-1200

Grand Rapids Women's Health

PATIENT INFORMATION Today's Date: _____

Patient Name: _____ Preferred Name: _____

Social Security Number: _____ Date of Birth: _____

Marital Status: ☐Married ☐Single ☐Other _____ Maiden Last Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Number: ☐Home ☐Work ☐Cell E-mail Address: _____

RACE:

☐ American Indian or Alaska
☐ Asian
☐ Black/ African American
☐ Native Hawaiian or Other Pacific Islander
☐ White/ Caucasian
☐ Other: _____
☐ Unknown
☐ Decline to Respond

ETHNICITY:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Decline to Respond

PREFERRED LANGUAGE:

☐ English ☐ Vietnamese
☐ Spanish ☐ Decline to Respond ☐ Other: _____

PATIENT GENDER:

☐ Female
☐ Male

Employer: _____ Employer Phone: _____

Spouse Name: _____ Date of Birth: _____ Phone: _____

Emergency Contact: _____ Phone _____ Relationship _____

PREFERRED PHARMACY:

Name: _____ Street: _____ City: _____

PHYSICIAN INFORMATION:

Primary Care Physician:_____ Phone: _____

Referring Physician: _____ Phone: _____

ACCOUNT INFORMATION:

Primary Insurance: _____

Policy Holder's Name (if other than patient): _____

Date of Birth (if other than patient): _____ Relationship to Patient: _____

Secondary Insurance: _____

Policy Holder's Name (if other than patient): _____

Date of Birth (if other than patient): _____ Relationship to Patient: _____

_____ _____

Patient Signature Date

Guardian Signature (if applicable): _____ Date: _____

Grand Rapids Women's Health

INSURANCE AND FINANCIAL POLICY

INSURANCE - A copy of your insurance card is required at each visit. If you do not have insurance, you may be asked to pay in full, make payment arrangements or reschedule. We participate with most, but not all insurance companies. It is your responsibility to call your insurance company or our office to determine if we participate with your insurance. If insurance does not pay within 90 days, we reserve the right to request payment in full. This is rare, but it is important that you recognize that insurance is a legal contract between you and your insurance company. It is important to keep us aware of all changes in your insurance coverage. We will submit a courtesy claim to the payer on record at the time of service.

CO-PAY, DEDUCTIBLES AND NON-COVERED SERVICES - All co-payments, deductibles and non-covered services are due at the time of service.

PREAUTHORIZATION, COST ESTIMATES AND BENEFIT CHECKS - Our office will assist you to the best of our ability with preauthorization, cost estimates and checking benefits. We will relay the information to you as quoted by your insurance company. We do not guarantee any insurance benefit quotes, cost estimates or pre-authorizations. To guarantee benefits or pre-authorizations, we recommend that you contact your insurance company. If your HMO plan requires that you have a referral from your primary care physician, this is your responsibility.

PAYMENT, NON-PAYMENT AND FEES - When payment can not be made in a timely manner, we encourage you to contact our billing department as soon as possible to make other arrangements on your account. If your account becomes past due and is forwarded to an outside collection agency, your account will be assessed collection fees based on the remaining balance. We accept cash, personal checks, money orders, Visa, MasterCard, and Discover. A $25.00 fee will be assessed on all returned checks.

MEDICAL RECORDS, FMLA and DISABILITY FORMS - We charge an administrative fee for completing disability or FMLA forms and copying/mailing medical records.

CANCELLATION/NO SHOW POLICY - We request that you give us 24-hour prior notice to change or cancel your non-emergent appointment. If you miss an appointment without providing notice, a $25.00 charge may be added to your account and must be paid in full before future appointments.

I have read, understand, and agree that I will be financially responsible for all services provided to me and all costs of collection incurred by the practice. I agree to make payments at the time of service, when applicable.

Release of Information: I authorize the release of any medical information necessary to process my insurance claims. I understand and agree that I am responsible for all amounts unpaid or not authorized by my insurance company.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Patient Name Printed **Date of Birth**

Grand Rapids Women's Health

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been offered or have received a copy of the Notice of Privacy Practices for Grand Rapids Women's Health.

_____ _____

Signature of Patient or Patient's Representative **Date**

☐ Patient refused to sign _____

Employee Signature & Date

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I hereby authorize ***Grand Rapids Women's Health*** to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe, and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

_____ _____

Signature of Patient or Patient's Representative **Date**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize ***Grand Rapids Women's Health*** release medical or other information necessary to process my insurance claim. I authorize payment of medical benefits to Grand Rapids Women's Health. I understand this authorization will remain in effect until revoked by me in writing.

_____ _____

Signature of Patient or Patient's Representative **Date**

Grand Rapids Women's Health

HIPAA AUTHORIZATION FORM

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: **Grand Rapids Women's Health**

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

WHO IS AUTHORIZED TO OBTAIN YOUR HEALTH INFORMATION?

Individual Name: _____Relationship_____

Individual Name: _____Relationship_____

Individual Name: _____Relationship_____

WHAT INFORMATION ARE YOU AUTHORIZING TO BE RELEASED? (Check one)

☐ **Any and all information** to include all clinical information, lab results, billing information and appointments. This may include discussions with my provider or nurse regarding my diagnosis, results and treatment options.

☐ **Limited release, please specify what can be released**

☐ Any and all clinical information related to my diagnosis, results and treatment options. This may include discussions with my provider or nurse regarding my diagnosis, results and treatment options.

☐ Billing Information (previous 3 years only) ☐ Appointment Dates and Times Only

☐ Please specify other _____

- We will ask you to verify this information once per year. If you make any changes to the listed parties, you will be asked to sign a new document.
- This authorization will not expire unless you specify a termination date. Please list the date of expiration if you wish for this authorization to expire. _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

Grand Rapids Women's Health

GYN Medical History and ROS

TO EXPEDITE YOUR VISIT, PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. THIS INFORMATION HELPS THE PHYSICIAN PROVIDE YOU THE BEST CARE

Name:_____ **DOB:** ____-____-_____ **Date:**___-___-_____
Name of Spouse/Partner: _____ **Referred By:**_____
Primary Care Physician: _____ ❑ **I do not have a primary care physician.**
Reason for today's visit:_____

Do you wish to have a chaperone? □Yes □No

Please check the box if you CURRENTLY have a symptom listed below

Constitutional
- ❑ Chronic Fatigue
- ❑ Recent weight loss
- ❑ Recent weight gain

Eyes
- ❑ Visual changes

Head, Ears, Nose, Mouth, Throat
- ❑ Unusual Headache
- ❑ lightheadedness
- ❑ Sinus symptoms
- ❑ Difficulty swallowing
- ❑ Neck mass/neck swelling

Breasts
- ❑ Breast lumps
- ❑ Breast tenderness
- ❑ Breast swelling
- ❑ Nipple discharge

Cardiovascular
- ❑ Chest pain
- ❑ Irregular heart beats
- ❑ Swelling of feet or ankles
- ❑ Fainting/lightheadedness

Respiratory
- ❑ Difficulty breathing (shortness of breath)
- ❑ Wheezing
- ❑ Chronic cough

Gastrointestinal
- ❑ Unexplained Nausea/vomiting
- ❑ Frequent diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Feeling full before you finish a normal meal
- ❑ Cramping or pain in the abdomen
- ❑ Black or tarry stools
- ❑ Bloating
- ❑ Change in stools

Genitourinary
- ❑ Urgency with urination
- ❑ Frequent urination
- ❑ Burning/painful urination
- ❑ Nighttime urination
- ❑ Blood in urine
- ❑ Uncontrolled leaking
- ❑ Difficulty urinating
- ❑ difficulty emptying bladder
- ❑ Decreased sexual desire
- ❑ Painful intercourse
- ❑ Spotting with or after intercourse
- ❑ Genital bumps/sores
- ❑ Irregular menstrual periods
- ❑ Painful menstrual periods
- ❑ Heavy & Prolonged menstrual periods
- ❑ Absence of menstrual periods
- ❑ Significant PMS
- ❑ Vaginal discharge
- ❑ Vaginal itching

Skin
- ❑ Rashes
- ❑ Itching

New lesions (moles)
- ❑ Changes in moles (color, shape, itching, irritation)
- ❑ Hair growth chin/face/abdomen
- ❑ Acne

Neurologic
- ❑ Lack of coordination
- ❑ Numbness or tingling
- ❑ Migraine headaches

Musculoskeletal
- ❑ Joint pain
- ❑ Joint swelling
- ❑ muscle pain
- ❑ muscle weakness
- ❑ Frequent back pain

Endocrine
- ❑ Excessive urination
- ❑ Excessive thirst
- ❑ Discharge from breasts
- ❑ Intolerant to cold
- ❑ Intolerant to heat

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty sleeping
- ❑ Physical abuse
- ❑ Emotional abuse
- ❑ sexual abuse

Hematologic/Lymphatic
- ❑ Experience easy bleeding
- ❑ Bruise easily

Any unusual swelling or lumps

Allergic/Immunologic
- ❑ Seasonal allergic symptoms
- ❑ Environmental allergic symptoms

Other symptoms not listed?

Do you see another physician for any of the symptoms listed?

PAST MEDICAL HISTORY: (*Check if you have ever had or been diagnosed with any of the following)*

EYES
- ❑ Eye problems

BREAST
- ❑ Fibrocystic Breast Disease

CARDIOVASCULAR
- ❑ Deep Venous Thrombosis
- ❑ Heart murmur
- ❑ *Heart problems*
- ❑ *High blood pressure*
  Usual Blood Pressure_____
- ❑ High Cholesterol
- ❑ Rheumatic fever
- ❑ Stroke

RESPIRATORY
- ❑ *Asthma*
- ❑ Chronic Lung Disease
- ❑ Pneumonia
- ❑ Tuberculosis

GASTROINTESTINAL
- ❑ Bowel Changes
- ❑ Gallbladder Problems
- ❑ Intestinal Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ *Yellow jaundice or hepatitis*

GYN / STDs
- ❑ Cervical pre-cancer/Dysplasia
- ❑ *Chlamydia*
- ❑ Endométriosis
- ❑ *Genital Warts*
- ❑ *Gonorrhea*
- ❑ *Herpes, Genital*
- ❑ Infertility
- ❑ Ovarian Cysts
- ❑ Premenstrual Syndrome
- ❑ *Syphilis*
- ❑ Trichomonas
- ❑ Uterine Fibroids

URINARY
- ❑ *Infection*
- ❑ Kidney Stones

AUTOIMMUNE
- ❑ *HIV*
- ❑ *LUPUS*

HEMATOLOGIC/BLOOD
- ❑ *Anemia*
- ❑ *Transfusions* when____

PSYCHIATRIC
- ❑ Anxiety
- ❑ *Depression*
- ❑ *Postpartum Depression*
- ❑ Mental Illness
- ❑ *Eating Disorder*

MUSCULOSKELETAL
- ❑ *Arthritis*
- ❑ Fracture/broken bone

NEUROLOGICAL
- ❑ *Epilepsy/Seizures*
- ❑ *Headaches*

ENDOCRINE
- ❑ *Diabetes* Type_____
  HgbA1C/when_____
  _____
- ❑ *Thyroid Disorder*

Cancer / Type:
Other:

HEALTH SCREENINGS – ***please indicate if appropriate***:

Bone Density Test	Year: _____	❑ Normal	❑ Abnormal	_____
Colonoscopy	Year: _____	❑ Normal	❑ Abnormal	_____
Mammogram	Year: _____	❑ Normal	❑ Abnormal	_____
Last Pap Smear	Year: _____	❑ Prior Abnormal Pap Smear	Year: _____	

ALLERGIES: *Please list all Medication /Food/Environmental Allergies and type of Reaction:*

PAST SURGICAL HISTORY: (*Please check any that you have had and indicate approximate date*)

❑ Appendectomy_____	❑ D&C_____	❑ Hysterectomy_____	❑ Tubal Ligation_____
❑ Breast_____	❑ Gallbladder_____	❑ Ovary_____	❑ Vaginal Repair_____
❑ Cesarean section ____	❑ Heart_____	❑ Tonsillectomy_____	

❑ Other _____
_____

CURRENT MEDICATIONS: List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary.

Medication	Strength	How Often	Prescribed By	Reason

IMMUNIZATION HISTORY: *Have you received the following vaccinations?*

❑ Hepatitis B Date_____ ❑ HPV Date_____
❑ Influenza Date_____ ❑ Varicella(Chicken pox) Date_____
❑ Tetanus/Tdap Date_____ ❑ Rubella (Measles) Date_____

FAMILY HISTORY: (*Please check if any of your close family members have had the following)* ❑ Adopted

Condition	Relation to you	Maternal(M) Paternal (P)	Diag Age	Condition	Relation to you	Maternal (M) Paternal (P)	Diag Age
❑ Breast Cancer				❑ High Blood Pressure			
❑ Ovarian Cancer				❑ Stroke			
❑ Colon Cancer				❑ Osteoporosis			
❑Other Cancer not mentioned:				❑ Bleeding/Blood Clot Disorder			
❑Diabetes				❑ Depression			
❑Heart Disease				❑ Other:			

GYNECOLOGICAL HISTORY: (*Fill in blanks or check boxes where appropriate*)

Age at first menstrual period: ____ Days between the first day of each period: ____ days Duration of flow: _____ days
Flow: ❑Light ❑ Meduim ❑Heavy Frequency that you change protection _____
1st Day of Last Menstrual Period: ____/____/_____
❑ Menopausal Ago at Menopause_____ ❑ Unexpected bleeding since menopause
How do you prevent pregnancy? _____

OBSTETRICAL HISTORY*:*

Pregnancies____ Full-Term_____ Pre-term_____ Abortions_____ Miscarriages_____ Tubal Pregnancies_____
Multiple____ Living____

Date	Weeks	Labor Hrs	Baby's Weight	Sex	Delivery Type	Your weight gain	Complications	Location/Physician

SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Steady Relationship ❑ Same-sex relationship
Are you sexually active? ❑ Yes ❑ No ❑ Plan to be sexually active in future
Your Education: Grade completed _____ ❑ Graduated High School ❑ GED ❑ Some College ❑ Graduated College ❑ Postgraduate Occupation_____
Tobacco Use ❑ Never ❑ Current ❑ Former ❑ Smokes every day ❑ Smokes some days
Alcohol Use ❑ Never ❑ Current ❑ Former Amount_____ Started_____ Stopped _____
Recreation Drug Use ❑ Never ❑ Current ❑ Former Type _____
Started_____ Stopped _____
Do you exercise regularly ❑ None ❑ Minimal ❑ Moderate ❑ Heavy ❑ Active but no formal exercise
Do you use your seat belt? ❑ Yes ❑ No

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____
Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother / Father / Sister / Brother / Children = 1st Degree Relatives
Aunt / Uncle / Grandparent / Niece / Nephew = 2nd Degree Relatives Cousin / Great Grandparent = 3rd Degree Relatives

Have you or any of your relatives been tested for hereditary cancer (BRCA / Colaris) in the past? YES NO
Have you ever been diagnosed with cancer? What site: Age:

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	**SELF**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	*EXAMPLE: Two or more relatives with a Lynch Syndrome cancer; one under age 50*			*Aunt – colon, Sister - uterine*	*47 yrs 60 yrs*
Y	N	Have YOU been diagnosed with uterine (endometrial) or Colorectal cancer before age 50?				
Y	N	Two or more relatives on the same side of the family w/any of the following, one diagnosed before 50 (please circle): *colon, uterine / endometrial, ovarian, stomach, small bowel, brain, kidney / urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/any of the following diagnosed at any age (please circle): *colon, uterine / endometrial, ovarian, stomach, small bowel, brain, kidney / urinary tract, ureter and renal pelvis*				
Y	N	Family member has a known Lynch Syndrome mutation				

		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	**SELF**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer – with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	Triple Negative breast cancer under age 60 (ER, PR and Her2 negative receptor status)				
Y	N	A family member with known BRCA mutation				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Patient is appropriate for further risk assessment and / or genetic testing
Information given to patient to review Follow-up appointment scheduled on _____

Patient offered genetic testing: Accepted OR Declined HCP Signature: _____

Grand Rapids Women's Health

Notice of Privacy Practices

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as neceesary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

We will not retaliate against you for filing a complaint.

Privacy Manager: Dawn Carpenter 555 Mid Towne NE Grand Rapids, MI 49503 616-588-1110

Effective: 9/1/2013