Dear New Patient:

Thank you for choosing Hands On Medicine as your primary care provider! We look forward to providing care for you and your family.

Enclosed you will find:

POLICY STATEMENT: a summary of Hands On Medicine's clinic policies. Please be sure to read our policies and sign at the bottom.

DEMOGRAPHIC FORM: name, address, insurance information, etc. Please fill out to the best of your knowledge.

HEALTH HISTORY FORM: knowing as much as possible about your Health History will help us tailor your health care to be as comprehensive as possible.

REQUEST & AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION: grants Hands On Medicine access to receive medical records from your previous primary care provider. Please fill out as completely as possible.

CONSENT TO RELEASE INFORMATION: if you consent to anyone to receive information about your health, please fill out this form.

ANNUAL QUESTIONNAIRE: a questionnaire on various health factors that we will ask you to complete annually.

NOTICE OF PRIVACY PRACTICES: a summary of Hands On Medicine's privacy policy, including your rights regarding your Protected Health Information (PHI) and our responsibilities in safeguarding this information.

Please fill out these forms and bring them with you to your first appointment (to insure we have all the information ready for their appointment, please arrive 15-20 minutes early).

Please feel free to call at (503) 281-0308 with any questions, and we look forward to being your health care partner in the years to come!

Shelda Holmes, FNP
Medical Director
Hands On Medicine

In an effort to provide the best medical services, we have established the following policies.
Your signature below signifies your willingness and understanding to comply with our policies.

POLICY STATEMENT: NOTICE OF PRIVACY PRACTICES _________ Initial

- Included with this Policy Statement is Hands On Medicine's Notice of Privacy Practices. By initialing above you acknowledge that you have received or been offered our Notice of Privacy Practices. This notice is also on public display in our lobby and available at any time from the front desk or by contacting Hands On Medicine's HIPAA Compliance Officer.

POLICY STATEMENT: PAYMENT POLICY ________ Initial

- You will be required to provide proof of insurance at every visit. In compliance with new Federal law, we will ask you for photo identification and may take your picture at your first office visit.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your particular insurance plan's network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Hands On Medicine, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf.
- If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to pay in full at the time of your office visit. We provide reduced rates for cash paying patients.
- If your deductible hasn't been met for the year, we may require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed.
- We accept cash and credit or debit card payments. We do not accept checks, except for balances sent in the mail. There is a $50.00 bounced check fee in addition to fees charged by your financial institution.
- Payment is due within 30 days of receiving your bill, after which time your account will incur a $20 a month charge. If your balance is not paid in full within 90 days your account will be sent to collections, at which point you will be charged an additional 35% of the balance you owe.
- Hands On Medicine is happy to continue providing care while you pay off this balance provided all office visits and other charges acquired from this day forward are paid in full at the time of service.

POLICY STATEMENT: PRESCRIPTION REFILL POLICY ____________ Initial

- Please allow 3-5 business days for all prescription refills. Ask your pharmacy to fax a refill request to the clinic at 503-281-4691 to speed up the process. If you use a mail order pharmacy, please allow 2 to 3 weeks.

POLICY STATEMENT: RECORDS _________ Initial

- We are happy to provide you one copy of your medical records gratis. However additional copies will require a charge in accordance with OAR 847-012-000.

POLICY STATEMENT: CHANGES IN DEMOGRAPHIC/INSURANCE INFORMATION ___________ Initial

- It is your responsibility to advise the clinic of any change in insurance coverage, or changes in name, address, or telephone number.

Signature: ____ Date: __________________________

If Parent or Guardian, Name of Child: ________________________________ Date: __________________________

POLICY STATEMENT: 24-HOUR CANCELLATION/NO-SHOW POLICY ______ Initial

- Our clinic policy requires a 24-hour cancellation notice for all appointments. Your appointment time is reserved for you. If you do not show or give the clinic less than 24-hour notice, you will receive a letter and a bill in the mail.
- If you cannot make it to your scheduled appointment, please call to reschedule (you may leave a message after hours). This allows us to give your appointment time to another patient who needs to be seen on that day, and helps us find time for you when you need to be seen on short notice.
- Unlike most other clinics that double-book office visits, we do not double-book our appointments and reserve office visits 20-40 minutes in length. Therefore, a 24-hour cancellation notice from you is vital to providing the longer appointments our patients require for comprehensive health care. There will be a $75 charge for a No-Show or less than 24-hour cancellation notice.
- This charge will not be paid by your insurance company.
- Patients should arrive at least 5 minutes prior to their scheduled appointment time. Late arrivals may be required to reschedule their appointment and the appointment recorded as a No-Show.
- If you accrue 3 or more No-Shows within 1 year, you may be dismissed from the practice.

POLICY STATEMENT: AFTER HOURS URGENT SERVICES (REACHING ON-CALL PROVIDER) ____________ Initial

- We provide 24/7 on-call coverage. If you have an urgent matter that can't wait until business hours, you may reach an on-call provider by calling the clinic and following the prompts on the outgoing message.
- Many insurance companies provide 24-hour nursing lines intended for this purpose and therefore may not cover this service. If this is the case, you will be charged $75.
- This service is not intended for non-urgent matters, making appointments, or prescription refill requests.

POLICY STATEMENT: MOTOR VEHICLE ACCIDENT/WORKER'S COMPENSATION CLAIMS _______ Initial

- We do accept claims for Motor Vehicle Accidents (MVA) and Worker's Compensation claims, however we require a $300 deposit prior to your first visit. This amount will be fully refunded following reimbursement from your insurance company.

POLICY STATEMENT: SPECIALTY REFERRAL POLICY _______ Initial

- Many private insurances allow patients to self-refer to specialists. We are happy to make recommendations for you.
- We work hard to maintain relationships with specialists. When you fail to show up to a referral appointment we have made for you, it reflects poorly on us and jeopardizes our ability to refer patients to these specialists in the future.
- Therefore, similar to our 24-Hour Cancellation/No Show Policy, if you repeatedly fail to show to a referred appointment, you will be dismissed from the practice.

POLICY STATEMENT: ATTENDING TO CHILDREN _________ Initial

- We know that it can be difficult to find childcare. However, the clinic is full of dangerous items.
- Please monitor your children at all times while at the clinic. We will not monitor your children during your office visit.
- We love kids, however children should not be present during procedures. It's unsafe.

Thank you and we look forward to caring for you and your family for years to come.

I have been given the opportunity to review Hands On Medicine's Notice of Privacy Practices.

Signature: ____ Date: ______________________

If Parent or Guardian, Name of Child: __________________________ Date: ______________________

YOUR HEALTH HISTORY

Please take the time to fill in this information. It really helps streamline our time together.

Name: ________________________________ Date: _____________ Age: _______ Date of Birth: _____________

Pronouns: __________ Gender: ___________ Occupation: ______________ Last medical evaluation: ___________

ALLERGIES

Please list any ALLERGIES or SENSITIVITIES to medications: Check here if NONE: O

Allergy:	Type of reaction:
____________________________	____________________________
____________________________	____________________________

If you have personal reasons to not receive blood products, please check here: O

Current Medications (prescription & non-prescription, please include dose):

____________________________ ____________________________

____________________________ ____________________________

Herbs or Supplements (including fluoride and multi-vitamins):

____________________________ ____________________________

____________________________ ____________________________

Which pharmacy do you use (name and location)?: ____

PERSONAL MEDICAL HISTORY: (Please check the appropriate circle)

	Current	Past	No		Current	Past	No
Mental health problems:	O	O	O	Anemia:	O	O	O
Seizures/epilepsy:	O	O	O	Bleeding/clotting disorder:	O	O	O
Developmental delays:	O	O	O	Hypertension/high blood pressure:	O	O	O
Attention deficit:	O	O	O	Heart murmur:	O	O	O
Eye/vision problems:	O	O	O	Gastrointestinal disorder:	O	O	O
Ear/hearing problems:	O	O	O	Kidney disease:	O	O	O
Dental problems:	O	O	O	Frequent bladder infections:	O	O	O
Eating disorder:	O	O	O	Incontinence:	O	O	O
Sleep problems:	O	O	O	Arthritis:	O	O	O
Seasonal allergies:	O	O	O	Diabetes:	O	O	O
Respiratory problems/Asthma:	O	O	O	Weight concerns:	O	O	O
Acid reflux:	O	O	O	Skin disorder: ______________	O	O	O
High cholesterol:	O	O	O	Serious infections:	O	O	O
Thyroid disorder:	O	O	O	Hepatitis/HIV/AIDS:	O	O	O

Other illnesses/surgeries/hospitalizations: ____

Do you have any menstrual problems and when was your last menstrual period? ____________________

Do you have a tendency for depression/anxiety?: ____________________________________

If yes, what treatment has been helpful?: ____

Have you ever had drug or alcohol treatment?: ______________________________________

Today's Date: ______________________ Patient Name: ______________________

FAMILY HISTORY

FAMILY HISTORY:	Relationship:		Relationship:
Diabetes		Alcoholism/Addiction	
Heart disease		Depression/Anxiety	
High blood pressure		Bleeding disorder	
High cholesterol		Strokes	
Cancer		Arthritis	
Other		Thyroid disease	
Other		Osteoporosis	

PREVENTATIVE CARE

Immunizations:	Date		Date
Tetanus booster (every 10 yrs):		Pneumonia Vaccine:	
Hepatitis A vaccine:		Flu Vaccine:	
Hepatitis B vaccine:		HPV Vaccine:	
Pertussis booster:		Other:	

Do you follow any special diet? If yes, please describe: ______________________

What form of contraception are you currently using, if any? ______________________

What are the names of other providers you consider a part of your healthcare team? ______________________

____

SOCIAL HISTORY

	CURRENT	PAST	NEVER	
Tobacco?	O	O	O	If yes, how much/day are you using?: ______
				For how many years have you used tobacco?: ______
Marijuana?	O	O	O	If yes, how much/day?: ______
Other Drugs?	O	O	O	If yes, what are you using and how much/day?: ______
Alcohol?	O	O	O	If yes, how many drinks per week?: ______
Caffeinated drinks?	O	O	O	How many per day?: ______
Regular exercise?	O	O	O	Please describe: ______

Sexual orientation: ______________________

Whom do you live with?: ______________________

Do you have social support (church, community groups, family)?: ______________________

____

What are your most pressing 1-2 issues you would like to address today?

____

____

____

____

____

____

____

____

REQUEST AND AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

FROM:

Provider/Facility Name ______________________ Phone Number ______________ Fax Number ______________

TO:

Provider/Facility Name ______________________ Phone Number ______________ Fax Number ______________

______________________ ______________ ______________

Patient Name (Please PRINT CLEARLY) Date of Birth Social Security

______________________ ______________ ______________

Patient Address City, State Patient Phone Number

INFORMATION REQUESTED:

O Entire Medical Records O Laboratory Test Results O X-ray, CT, MRI, US and Reports

O Therapy Records O Psych NP Records O Lactation Records

O Massage Therapy Records O Other/Specific Information Only: Please Specify ______________________

____

O RESTRICTION REQUEST (check if you are exercising this right). You have the right to request that HANDS ON MEDICINE restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. Please specify the type of protected health information you would like restricted and the dates of the information:

O Lab results O Billing O Treatment Information O Other (please explain): ______________________

Dates of Information: ____

State the restriction you want to apply to that protected health information:

____

If you consent to release of the following records, corresponding circles must be INITIALED:

_______ HIV/AIDS Related Records _______ Genetic Testing Information

_______ Mental Health Information _______ Drug/Alcohol Diagnosis, Treatment or Referral Information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information

By signing below, I agree to release the aforementioned health information and I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I may revoke this authorization in writing at any time, to the extent that action has not been taken in reliance upon this authorization.

If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on ____________ (insert applicable date or event). There may be fees for providing copies.

______________________________________ ______________________

(Signature of patient or person authorized by law) (Date)

O Check here if you are the parent or guardian.

SCREENING, BRIEF INTERVENTION, AND REFERRAL AND TREATMENT (SBIRT)

Once a year, all of our patients are asked to complete this form because these factors can affect your health as well as medications you take. Please help us provide you with the best medical care by answering the questions below.

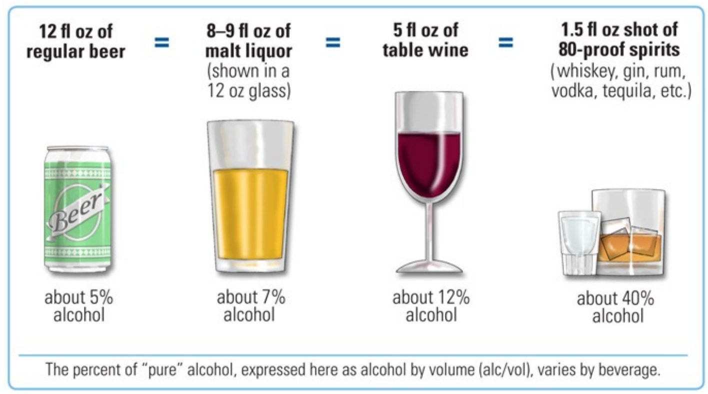
Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

ALCOHOL:
How many times in the past year have you had 4 or more drinks?

- o None
- o 1 or more times



CANNABIS:
Do you use cannabis (marijuana, pot)?

- o Yes
- o No

DRUGS: Recreational drugs include methamphetamines (speed, crystal), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

- o None
- o 1 or more times

MOOD:
During the past two weeks, have you been bothered by little interest or pleasure in doing things?

- o Yes
- o No

During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?

- o Yes
- o No

During the past two weeks, have you been bothered by worry, being on edge, nervous, afraid, irritable or anxious?

- o Yes
- o No

Today's date:	PCP:	O I am a new patient	O Information update

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Pronouns: O He/Him O She/Her O They/Them O Other:	Marital status: O Single O Divorced O Married O Separated O Partnered O Widowed

Is this your legal name? O Yes O No	If not, what is your legal name?	(Former name):	Birth date:	Age	Sex/Gender:

Race: Native American, Eskimo, Aleutian O Asian/Pacific Islander O Black O Multi-Racial O White O Other O Unknown O

Ethnicity: Hispanic O Non-Hispanic O Unknown O Other O	Preferred language:

Mailing address:	City:	State:	Zip code:
Social Security number:	Email address:	Phone number: ( )	Initial here to consent to receive detailed messages:
Occupation:	Employer:		Employer phone number: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? O Yes O No

PRIMARY INSURANCE:

Subscriber's name:	Subscriber's social security:	Birth date:	Member number	Copay: $

Patient's relationship to subscriber: O Self O Spouse O Child O Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize Hands On Medicine to treat me. I authorize my insurance benefits be paid directly to Hands On Medicine. I understand that I am financially responsible for any balance. I also authorize Hands On Medicine to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE	DATE

CONSENT TO RELEASE INFORMATION TO SPOUSES/PARTNERS/ADULT CHILDREN ETC.

Date: ____

I, ____ give written consent to release information regarding my medical treatment from Hands on Medicine to the persons named below:

Name: ____
Phone: ____
Relationship: ______________________________________

Name: ____
Phone: ____
Relationship: ______________________________________

By signing this form, I acknowledge that I am giving consent for the staff and providers to speak with the above persons about my medical treatment here at Hands On Medicine. You have the right to revoke this consent at any time, provided you do so in writing.

Patient Signature: ____ Date: __________________________

-or-

Patient Representative: ____ Date: __________________________

Description of Representative's Authority: ____

NOTICE OF PRIVACY PRACTICES

Effective Date: June 16, 2016

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.

If you have any questions about this notice, please contact:
Jacob Aiello
HIPAA Compliance Officer
HANDS ON MEDICINE
5311 N Vancouver Avenue
Portland, Oregon 97217
(503) 281-0308, extension 1006

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Hands On Medicine. Your health information may include information created and received by Hands On Medicine, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your provider may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The provider may use your medical history to decide what treatment is best for you. The provider may also tell another provider about your condition so that provider can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for Hands On Medicine in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

  For payment. We may use and disclose health information about you so that the treatment and services you receive at Hands On Medicine may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- For Health Care Operations. We may use and disclose health information about you in order to run Hands On Medicine and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

- Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. Examples of disclosures requiring your authorization include disclosures to your partner, spouse, your children and your legal counsel.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- <u>Right to Inspect and Copy</u>. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Medical Records department in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our Medical Records department. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- <u>Right to Amend</u>. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Hands On Medicine.

  To request an amendment, complete and submit the Request To Amend Health Information form to Hands On Medicine's Medical Director.

  We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy.
- Is accurate and complete.

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 10 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

  <u>Right to an Accounting of Disclosures</u>. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number

  of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request in writing to Hands On Medicine's HIPAA Compliance Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the "Request for Restriction On Use/Disclosure of Medical Information" to our Medical Records department.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the "Request for Restriction On Use/Disclosure of Medical Information and/or Confidential Communication" to our Medical Records department. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy available for public display in our reception area, and on our website.

  To obtain such a copy, contact Hands On Medicine's HIPAA Compliance Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location with its effective date in the bottom right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location, a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights, Pacific Region
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, California 94103
(800) 368-1019

To file a complaint with Hands On Medicine, contact:

Jacob Aiello
HIPAA Compliance Officer
HANDS ON MEDICINE
5311 N Vancouver Avenue
Portland, Oregon 97217
(503) 281-0308, extension 1006

You will not be penalized for filing a complaint.