# William O. Dickey M.D., John P. Molina Au.D. & Michael R. Iliff, Au.D. Patient Profile and Consent

| | | | | |
|---|---|---|---|---|
| Legal Name (First MI Last) | | Patient SS# | | Patient Date of Birth |
| Address | | Sex: Email Address | | Marital Status |
| City, State, Zip | | Phone #1/Type of Number | | Phone #2/Type of Number |
| Employer | Occupation | | Please tell us how your heard about our practice | |
| Guarantor Name | Guarantor SS# | | Guarantor Date of Birth | |
| Referring Physician | Primary Care Physician | | | |

**Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.

**Consent for Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.

**Consent to Communicate Medical Results:** I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):

| | **Use info above** | **Okay to leave voice mail?** | **Ok to leave message with another person (see below)** |
|---|---|---|---|
| ❒ Call my work number | ❒ | ❒ Yes ❒ No | ❒ Yes ❒ No |
| ❒ Call my cell phone: | ❒ | ❒ Yes ❒ No | ❒ Yes ❒ No |
| ❒ Call my home number | ❒ | ❒ Yes ❒ No | ❒ Yes ❒ No |
| ❒ Mail to my home address | ❒ | ❒ Mail to a different address (at right): | |

*In the event that I am not available to receive medical results when called upon, I authorize William O. Dickey M.D. P. C., John P. Molina Au.D. or Michael R. Iliff Au.D. to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold William O. Dickey M.D., John P. Molina Au.D. or Michael R. Iliff Au.D. responsible for information not conveyed to me through these persons.* (Please indicate below which family members are authorized to receive result information.)

**Family Information *(Please list all other members of your household even if not authorized to receive results.)***

| Name (First MI Last) | Male ❒ | Female ❒ | Date of Birth | Relation | *OK to Release Results? No ❒ Yes ❒ |
|---|---|---|---|---|---|
| Name (First MI Last) | Male ❒ | Female ❒ | Date of Birth | Relation | *OK to Release Results? No ❒ Yes ❒ |

**Emergency Contact information**

| **Name of relative or friend to contact in case of an emergency** | | |
|---|---|---|
| Name | Relation | Phone |

***Please read and initial each of the items below***

_____ **I certify to the accuracy of the above information and understand that I am personally responsible for the full amount of my charges regardless of insurance coverage. I authorize the release of any medical or other information necessary to process claims.**

_____ **I further authorize payment of medical benefits directly to the undersigned physician.**

_____ **I also herby acknowledge that I received William O. Dickey M.D., John P. Molina Au.D. & Michael R. Iliff Au.D.'s Notice of Privacy Practices.**

_____ **I understand that if I am unable to make my appointment, that I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule, or be worked into the day. If I do not show for my appointment and do not call the office to cancel my appointment in advance, I will be considered a no show and will be charged a $25 no show fee.**

_____ **I also understand if my check is returned for non-sufficient funds, I will be responsible for paying a $25.00 fee in addition to re-issuing payment for the returned check.**

_____ _____ _____ _____

**Name (please Print)** **Signature** **Relationship to patient** **Date**

# DR. WILLIAM O. DICKEY M.D. PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item. Please Print.**

**NAME**: _____ Date of birth: _____
Last First M

**PHARMACY PREFERENCE (NAME/LOCATION)**:_____

**PURPOSE FOR VISIT**: **What is the main reason you are seeing the doctor today?**

| |
|---|
| |
| |
| |

**MEDICATIONS**

**Do you take any medications *including aspirin, vitamins, over-the-counter, or herbal medications*?** ☐Yes ☐No

| ***Medication Name*** | ***Dose*** | ***How Often Taken*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATION AND OTHER ALLERGIES** Are you allergic/sensitive to any medications? ☐Yes ☐No

| ***Medication Name*** | ***Reaction*** |
|---|---|
| | |
| | |
| | |
| Have you ever had an allergy test? **☐Yes ☐No** Findings of test(s):<br>If yes, what year? | |

***Check all that apply***

| | |
|---|---|
| ☐ American Indian or Alaska Native | ☐ White |
| ☐ Asian | ☐ Hispanic or Latino |
| ☐ Black or African American | ☐ Decline to State |
| ☐ Native Hawaiian or Other Pacific Islander | |
| ☐ Some Other Race | Preferred Language:_____ |

***Have you ever been DIAGNOSED with any of the following problems?***

| | **Yes** | **No** | **Year** | **Comment** |
|---|---|---|---|---|
| CANCER (please list type): | ❒ | ❒ | | |
| Nose and Sinus: | | | | |
| **Nasal Allergies?** | ❒ | ❒ | | |
| **Chronic Infections?** | ❒ | ❒ | | |
| Ears | | | | |
| **Hearing Loss** | ❒ | ❒ | | |
| **Ear Infections or drainage** | ❒ | ❒ | | |
| Cardiovascular | | | | |
| **High/Elevated Cholesterol** | ❒ | ❒ | | |
| **High Blood Pressure** | ❒ | ❒ | | |
| **Other Heart Problems** | ❒ | ❒ | | |
| Respiratory | | | | |
| **Asthma** | ❒ | ❒ | | |
| **COPD** | ❒ | ❒ | | |

| | | | |
|---|---|---|---|
| **Tuberculosis** | ❒ ❒ | | |

**NAME**: _____ Date of birth: _____

**PAST MEDICAL HISTORY** ***Continued***

| | Yes | No | Year | Comment |
|---|---|---|---|---|
| Gastrointestinal | | | | |
| **Hepatitis** | ❒ | ❒ | | |
| **Reflux** | ❒ | ❒ | | |
| **Stomach ulcers** | ❒ | ❒ | | |
| Urogynecologic | | | | |
| **Renal Failure** | ❒ | ❒ | | |
| **Are you Pregnant or nursing?** | ❒ | ❒ | | |
| Mental and Emotional | | | | |
| **Depression** | ❒ | ❒ | | |
| **Anxiety** | ❒ | ❒ | | |
| Endocrine | | | | |
| **Diabetes** | ❒ | ❒ | | |
| **Thyroid deficiency** | ❒ | ❒ | | |
| **Thyroid excess** | ❒ | ❒ | | |
| Hematologic | | | | |
| **Anemia** | ❒ | ❒ | | |
| Immunity | | | | |
| **HIV** | ❒ | ❒ | | |
| **Mononucleosis** | ❒ | ❒ | | |
| Other Not Listed Above | | | | |
| **Problem:** | ❒ | ❒ | | |

| | |
|---|---|
| ***Have you had a flu vaccine in the last 12 months? If so please indicate date.*** | ☐**Yes** ☐**No** **Date:**_____ |

**PAST SURGICAL HISTORY**

| Have you ever had ***any*** surgery? | ☐**Yes** ☐**No** | Please list below: |
|---|---|---|
| **Year** | **Procedure** | **Surgeon** |
| | | |
| | | |
| | | |
| | | |

**PAST HOSPITALIZATIONS**

| Have you ever been hospitalized for a medical problem before? | ☐**Yes** ☐**No** | Please list below: | |
|---|---|---|---|
| **Year** | **Reason for Admission** | **Date** | **Physician** |
| | | | |
| | | | |
| | | | |
| | | | |

**ANESTHESIA HISTORY**

| **Have you ever had any problems with anesthesia (being numbed or put to sleep)?** | **If so, please indicate anesthesia type and reaction(s) below:** ☐**Yes** ☐**No** |
|---|---|
| Comments: | |

**NAME**: _____ Date of birth: _____

**FAMILY HISTORY** ***Please mark all that apply:***

| | Mother | Father | Brother | Sister | Comment |
|---|---|---|---|---|---|
| Specific Anesthesia problem | ❒ | ❒ | ❒ | ❒ | |
| Ears: | | | | | |
| **Hearing Loss before age 20** | ❒ | ❒ | ❒ | ❒ | |
| **Hearing Loss after age 20** | ❒ | ❒ | ❒ | ❒ | |
| Nose and Sinus: | | | | | |
| **Nasal Allergies** | ❒ | ❒ | ❒ | ❒ | |
| Cardiovascular: | | | | | |
| **High Blood Pressure** | ❒ | ❒ | ❒ | ❒ | |
| **Other Heart Problems** | ❒ | ❒ | ❒ | ❒ | |
| Respiratory: | | | | | |
| **Asthma** | ❒ | ❒ | ❒ | ❒ | |
| **Lung Cancer** | ❒ | ❒ | ❒ | ❒ | |
| Neurologic: | | | | | |
| **Stroke** | ❒ | ❒ | ❒ | ❒ | |
| Hematologic | | | | | |
| **Bleeding/clotting problem** | ❒ | ❒ | ❒ | ❒ | |

**SOCIAL HISTORY**

| | | | |
|---|---|---|---|
| Have you ever used tobacco? | ☐**Yes** | ☐**No** | Comments (indicate amount if appropriate): |
| Do you currently use tobacco? | ☐**Yes** | ☐**No** | |
| Do you drink alcohol? | ☐**Yes** | ☐**No** | Comments (indicate amount if appropriate): |
| Do you use any recreational drugs? | ☐**Yes** | ☐**No** | Comments (indicate amount if appropriate): |

**REVIEW OF SYSTEMS** ***Have you RECENTLY had any of the following problems?***

| | **Yes** | **No** | **Comment** |
|---|---|---|---|
| General Health Problems: | | | What is your current Height: _____ Weight: _____ |
| **Fever** | ❒ | ❒ | |
| **Unintentional Weight Loss/Gain** | ❒ | ❒ | |
| **Fatigue** | ❒ | ❒ | |
| Cardiovascular Problems: | | | |
| **Blacking out/Fainting** | ❒ | ❒ | |
| **Bluish discoloration of lips/fingernails** | ❒ | ❒ | |
| **Acute Chest pain** | ❒ | ❒ | |
| **Irregular heartbeat** | ❒ | ❒ | |
| **Swelling of ankles** | ❒ | ❒ | |
| Respiratory Problems: | | | |
| **Frequent non-productive cough** | ❒ | ❒ | |
| **Frequent productive cough** | ❒ | ❒ | |
| **Shortness of breath** | ❒ | ❒ | |
| **Wheezing** | ❒ | ❒ | |
| Gastrointestinal Problems: | | | |
| **Abdominal pain** | ❒ | ❒ | |
| **Constipation** | ❒ | ❒ | |
| **Diarrhea** | ❒ | ❒ | |
| **Heartburn** | ❒ | ❒ | |
| **Nausea** | ❒ | ❒ | |
| **Vomiting** | ❒ | ❒ | |
| Neurologic Problems: | | | |
| **Numbness** | ❒ | ❒ | |
| **Seizures** | ❒ | ❒ | |
| **Weakness** | ❒ | ❒ | |
| Endocrine Problems: | | | |
| **Feel cold all the time** | ❒ | ❒ | |
| **Feel hot when others do not** | ❒ | ❒ | |
| **Increased appetite** | ❒ | ❒ | |
| Hematologic | | | |
| **Bleeding excessively after injury** | ❒ | ❒ | |
| **Bruising easily** | ❒ | ❒ | |
| **Bleeding into joints** | ❒ | ❒ | |

**Signature:** _____ **Date:** _____

# Advanced Beneficiary Notice Diagnostic Procedures

It is the goal of our office to offer you the best treatment plan based on the most accurate diagnosis. To obtain the diagnosis, our Doctors may recommend procedures or tests to be performed during your visit.

These procedures/tests may include but are not limited to:

Nasal Endoscopy- an in-office surgical procedure using a sterile rigid telescope to examine the nasal cavity.

Laryngoscopy- an in-office surgical procedure using a sterile flexible telescope to examine the larynx (throat).

Comprehensive Hearing Tests

Depending on your insurance company's rules and regulations, you may be financially responsible for some or all of the cost of these procedures. Your insurance company calls these "Surgery" charges even though they are not performed in the operating room. It can be confusing when you receive a bill and/or explanation of benefits.

□ **I understand that my co-pay is for a routine office visit. Additional diagnostic procedures (possibly billed as office surgery) and tests are not included in a routine office visit and may result in additional charges. I will assume financial responsibility for charges that may be billed to me as a result of any diagnostic procedures/tests performed. Depending on my specific benefit plan the procedure/test charges may be applied to an annual deductible or coinsurance.**

_____

Printed name of patient

_____

Patient's Signature or Legal Guardian Date

# William O. Dickey M.D. & John P. Molina Au. D. Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.

A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. We know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in this Notice.

**1.) OUR COMMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU.**

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called "protected health information" or "PHI." This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to PHI; and
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

***We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official (Kathy Hannah, Practice Administrator).***

**2.) HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU**

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or health care operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

**Treatment:** We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose PHI when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider. For example, if you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to any medications.

We may also disclose PHI about you for the treatment activities of another health care provider. For example, we may send a report about your care from us to a physician that we refer you to so that the other physician may treat you.

**Payment:** We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive. For example, we may ask for payment approval from your health plan before we provide care or services. We may use and disclose PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose PHI for billing, claims management, and collection activities. We may disclose PHI to insurance companies providing you with additional coverage. We may disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us.

We may also disclose PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

**Health Care Operations:** We may use and disclose PHI in performing business activities that are considered health care operations. Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs. We may use and disclose PHI about you in the following health care operations.

- Reviewing and improving the quality, efficiency and cost of care that we provide to our patients. For example, we may use PHI about you to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment that we provided to others.
- Improving health care and lowering costs for groups of people who have similar health problems and helping to manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives, and educational classes.
- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you and our other patients.
- Providing training programs for students, trainees, health care providers, or non-health care professionals (for example, billing personnel) to help them practice or improve their skills.
- Cooperating with outside organizations that assess the quality of the care that we provide.
- Cooperating with outside organizations that evaluate, certify, or license health care providers or staff in a particular field or specialty. For example, we may use or disclose PHI so that one of our nurses may become certified as having expertise in a specific field of nursing.
- Cooperating with various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with the law and managing our business.
- Assisting us in making plans for our practice's future operations.
- Resolving grievances within our practice.
- Reviewing our activities and using or disclosing PHI in the event that we sell our practice to someone else or combine with another practice.
- Business planning and development, such as cost management analyses.
- Business management and general administrative activities of our practice, including managing our activities related to complying with the HIPAA Privacy Rule and other legal requirements.
- Creating "de-identified" information that is not identifiable to any individual.

If another health care provider, company, or health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company. For example, such health care operations may include: reviewing and improving the quality, efficiency and cost of care provided to you; reviewing and evaluating the skills, qualifications, and performance of health care providers; providing training programs for students, trainees, health care providers, or non-health care professionals; cooperating with the outside organizations that evaluate, certify, or license health care providers or staff in a particular field or specialty; and assisting with legal compliance activities of that health care provider or company.

We may also disclose PHI for the health care operations of an "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the joint care provided by a hospital and the doctors who see patients at the hospital.

**Communication From Our Office:** We may contact you to remind you of appointments, convey results of testing and to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

**OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION**

**Uses and Disclosures For Which You Have the Opportunity To Agree or Object**

We may use and disclose PHI about you in some situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you. If you do not object, then we may makes these types of uses and disclosures of PHI.

- **Individuals Involved in Your Care or Payment for Your Care:** We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests. For example, if you are brought into this office and we are unable to communicate normally with your physician for some reason, we may find it is in your best interest to give your prescription and other medical

supplies to the friend or relative who brought you in for treatment. We may also use and disclose PHI to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other things that contain PHI about you.

**OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT**

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply.

**Required by Law:** We may use and disclose PHI as required by federal, state, or local law. Any disclosure complies with the law and is limited to the requirements of the law.

**Public Health Activities:** We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

- To prevent or control disease, injury, or disability;
- To report disease, injury, birth, or death;
- To report child abuse or neglect;
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- To locate and notify persons of recalls of products that they may be using;
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

**Abuse, neglect, or Domestic Violence:** We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

**Health Oversight Activities:** We may disclose PHI to a health oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.

**Lawsuits and Other Legal Proceedings:** We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

**Law Enforcement:** Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency;
- To alert law enforcement of a death that we suspect was the result of criminal conduct;
- Required by law;
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a crime or suspected crime committed at our office; or
- In response to a medical emergency not occurring at the office, if necessary to report a crime, including the nature of the crime, the location of the crime or the victim, and the identity of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors:** We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.

**Organ and Tissue Donation:** If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.

**Research:** We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

**To Avert a Serious Threat to Health of Safety:** We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.

**Specialized Government Functions:** Under certain circumstances we may disclose PHI:

- For certain military and veteran activities, including determination of eligibility for veterans benefits and where deemed necessary by military command authorities;
- For national security and intelligence activities;
- To help provide protective services for the president and others;
- For the health or safety of inmates and others at correctional institutions or other law enforcement custodial situations for the general safety and health related to corrections facilities.

**Disclosures required by HIPAA Privacy Rule:** We are required to disclose PHI to the Secretary of the United States Department of Health and Human services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you (those requests are described in Section 3 of this Notice).

**OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRE YOUR AUTHORIZATION**

**Workers' Compensation:** We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization.

**3.) YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU:** Under federal law, you have the following rights regarding PHI about you:

**Right to Request Restrictions:** You have the right to request additional restrictions on the PHI that we may use for treatment, payment and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. *We are not required to agree to your request.* If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to our Privacy Official. In your request, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); and (3) to whom you want these restrictions to apply.

**Right to Receive Confidential Communications:** You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing to our Privacy Official. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). We are required to accommodate *reasonable* requests.

**Right to Inspect and Copy:** You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your medical and billing records, but does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI, please contact our Privacy Official. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

**Right to Amend:** You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing, or if you do not give us a reason for the request.

**Right to Receive an Accounting of Disclosures:** You have the right to request an "accounting of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years *other than* disclosures made: for treatment, payment, and health care operations; for use in or related to a facility directory; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your personal representative, or for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes) and disclosures made before April 14, 2003. If you wish to make such a request, please contact our Privacy Official identified on the last page of this Notice. The first list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

**Right to a Paper Copy of this Notice:** You have a right to receive a paper copy of this Notice at any time. You are entitled to a paper copy of this Notice even if you have previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Privacy Official listed on the last page of this Notice.

**4.) COMPLAINTS**: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Official listed on the last page of this notice. We will not retaliate or take action against you for filing a complaint.

**5.) QUESTIONS:** If you have any questions about this Notice, please contact our Privacy Official at the address and telephone number listed below.

**6.) PRIVACY OFFICIAL CONTACT INFORMATION :** You may contact our Privacy Official at the following address and phone number:

Privacy Official, William O. Dickey M.D.
9397 Crown Crest Blvd, Suite 307,
Parker, CO 80138 (303) 840-9690