THE CARRELL CLINIC
9301 N. CENTRAL EXPRESSWAY #500
DALLAS, TX 75231
PHONE 214-220-2468
FAX 469-232-9738
WWW.WBCARRELLCLINIC.COM

WELCOME

Thank you for choosing the Carrell Clinic to take care of your medical treatment. Completing the enclosed new patient information packet prior to your appointment will help make the registration process more efficient. For your convenience, you can securely email or fax your completed paperwork to wbccmedrecords@wbcarrellclinic.com or 469-232-9738.

Please bring the following to your appointment:

- Driver's license or Photo Identification
- Insurance cards
- Any previous diagnostic testing such as x-rays, MRI, CT scans, EMG/Nerve Conduction Studies and/or previous operative reports and operative images. Please provide both images and written report where applicable. Please bring these items with you to the appointment. **DO NOT MAIL OR DROP THEM OFF.**
- It is the insured's responsibility to obtain any necessary information or referral from their insurance company before the appointment including any out of network benefits.

At the time of service you will be required to pay your co-pay or a percentage of your unpaid deductible. Contact your insurance company if you are unsure of these amounts.

If you have any questions or concerns, please do not hesitate to contact the clinic.

Thank You,

The Carrell Clinic Staff

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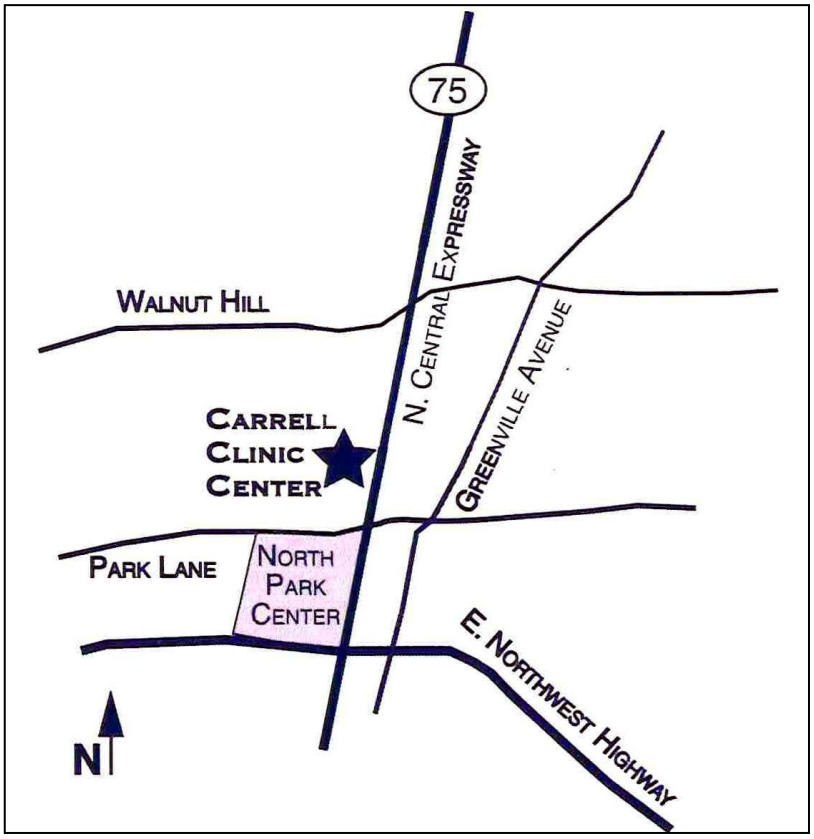
Location



Directions

Heading South on 75 North Central Expressway:
Exit Walnut Hill Lane, go through Walnut Hill intersection, stay on south bound service road for 0.3 miles turn right into parking lot of the five story white building.

Heading North on 75 North Central Expressway:
Exit Walnut Hill, U-turn, go on south bound service road for 0.3 miles turn right into parking lot of the five story white building.

The Carrell Clinic - Hours of Operation

Monday – Friday 8:30am – 5:30pm

THE CARRELL CLINIC PHYSICIAN YOU ARE SEEING TODAY: _____

PREFERRED PHARMACY:_____ PHAR.ADDRESS:_____ PHAR. PHONE#:_____

PATIENTS LAST NAME:_____ FIRST NAME:_____MIDDLE INITIAL:_____

PREFERRED NAME:_____ MAIDEN NAME:_____

DATE OF BIRTH:_____ SEX: M☐ F☐ SOCIAL SECURITY #:_____

OPTIONAL PATIENT INFORMATION (PLEASE CIRCLE YOUR SELECTION)

RACE:☐AMER.INDIAN ☐ALASKA NATIVE ☐WHITE ☐NAT HAWAIIAN ☐ PACIFIC ISLANDER ☐ AFRICAN AMER. ☐ ASIAN☐OTHER DECLINE☐

ETHINICITY:☐NOT HISPANIC/ LATINO☐HISPANIC/ LATINO ☐ DECLINE

PRIMARY LANGUAGE:☐ARABIC☐CHINESE☐ENGLISH☐FILIPINO☐FRENCH☐GERMAN☐GREEK☐HINDI☐ITALIAN☐JAPANESE ☐KOREAN☐POLISH☐PORTUGESE☐RUSSIAN☐SPANISH☐VIETNAMESE☐DECLINED☐OTHER☐N/A

MARITAL STATUS: ☐S ☐M ☐D ☐W DRIVERS LICENSE STATE AND #: _____

STREET ADDRESS: _____

ZIP:_____ CITY: _____ STATE:_____ COUNTY:_____ COUNTRY:_____

***EMPLOYER**: _____ **OCCUPATION**: _____

PHONE: HOME:_____ WORK:_____ CELL:_____ PREFERRED :_____

FAX:_____ PAGER:_____ EMAIL:_____

PREFERRED COMMUNICATION:☐DECLINE☐EMAIL☐FAX☐MAIL☐PATIENT PORTAL☐CELL PHONE☐HOME PHONE☐WORK PHONE☐TEXT

***EMERGENCY CONTACT:_____ PHONE NUMBER**: _____

FINANCIALLY RESPONSIBLE PARTY

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____ RELATION TO PATIENT:_____

ADDRESS IF DIFFERENT FROM PATIENT: STREET:_____

CITY:_____ STATE:_____ ZIP:_____

INSURANCE INFORMATION (MUST HAVE INSURED DOB FOR CLAIM TO BE FILED)

PRIMARY INSURANCE NAME:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

INSURED NAME:_____ INSURED'S DOB:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

SECONDARY INSURANCE NAME: _____

POLICY NUMBER:_____ GROUP NUMBER:_____

INSURED NAME:_____ INSURED'S DOB:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

REFERRING PHYSICIAN: LAST NAME:_____ FIRST NAME:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

PRIMARY CARE PHYSICIAN: LAST NAME:_____ FIRST NAME:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

*REASON FOR VISIT (BODY PART):_____ ☐RIGHT☐LEFT *DATE OF INJURY:_____

*WAS THIS AN ACCIDENT:☐Y ☐N ON THE JOB:☐Y☐N MOTOR VEHICLE ACCIDENT: ☐Y ☐N DATE:_____

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize W.B. Carrell clinic to furnish medical and billing information to my referring physician, other providers of medical services, my insurance provider(s), and/or my spouse or guardian as necessary to facilitate my medical care or to recover expenses for services rendered by health care providers of the clinic. I understand that I have the right to specify, in writing that my private health information be restricted from dissemination to any or all of the above.

I hereby assign any and all insurance benefits to the clinic to pay my obligation for medical and/or surgical expenses. I understand that I am responsible for any charges which may be denied or excluded by my insurance prover(s), expect those charges which are excluded based on a managed care contract between the insurance company and the clinic. I understand that I am financially responsible for all charges not covered by an insurance company.

PRINT PATIENT NAME: _____

SIGNATURE: _____ DATE:_____

HEALTH HISTORY FORM

NAME_____ DOB:_____ DATE: _____

The purpose of this form is to gather your health history. Please be as thorough as possible:

Past Medical History

- ☐ *NO MEDICAL PROBLEMS
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety Disorder
- ☐ Asthma (daily medication)
- ☐ Atrial Fibrillation
- ☐ Blindness
- ☐ Blood Clots/DVT
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cellulitis
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Cirrhosis
- ☐ Claustrophobia
- ☐ Clotting Disorder
- ☐ Coagulation Defect
- ☐ Colitis
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ CVA (Cerebral Vascular Accident/stroke)
- ☐ Deafness
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus, Type I
- ☐ Diabetes Mellitus, Type II
- ☐ Diabetic Neuropathy
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Esophageal Reflux
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Gout (unsp)
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Heart Murmur (MI)
- ☐ Hepatitis Type _____
- ☐ Hypertension (HBP)
- ☐ HIV/AIDS
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Chronic
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Musculoskeletal Deformities, Congenital
- ☐ Neuropathy
- ☐ Organ Transplant Type:_____
- ☐ Other: _____
- ☐ Pacemaker
- ☐ Panic Disorder
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Prostate Disease
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure
- ☐ Sickle-Cell Trait
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thrombophlebitis (TPB)
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Urinary Tract Infection

Past Orthopedic Medical History

- ☐ NO PAST ORTHOPEDICAL MEDICAL PROBLEM
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Contusion
- ☐ Dislocation
- ☐ Fibromyalgia
- ☐ Fracture where_____
- ☐ Ganglion
- ☐ Herniated Disc
- ☐ Multiple Sclerosis
- ☐ Myopathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Other: _____
- ☐ Osteoporosis
- ☐ Pain- Ankle/Foot
- ☐ Pain- Back
- ☐ Pain-Chronic
- ☐ Pain- Elbow/Upper Arm
- ☐ Pain-Forearm
- ☐ Pain- Hand/Fingers
- ☐ Pain- Hip/Thigh
- ☐ Pain- Joint
- ☐ Pain- Knee
- ☐ Pain- Leg/Calf
- ☐ Pain- Limb
- ☐ Pain- Neck
- ☐ Pain- Shoulder
- ☐ Pain- Wrist
- ☐ Pain- Scoliosis
- ☐ Reflex Sympathetic Dystrophy
- ☐ Sprain
- ☐ Swelling

Family Medical History

Please answer as accurately as possible

- ☐ Family History Unknown
- ☐ No Pertinent Family History
- ☐ Family History of Arthritis
- ☐ Family History of Bleeding Disorder
- ☐ Family History of Cancer
- ☐ Family History of Hypertension (HBP)
- ☐ Family History of Leukemia
- ☐ Family History of Lung Disease
- ☐ Family History of Malignant Hyperthermia
- ☐ Family History of Musculoskeletal Diseases

HEALTH HISTORY FORM

NAME_____ DOB:_____ DATE: _____

- ☐ Family History of Diabetes
- ☐ Family History of Heart Attack
- ☐ NONE
- ☐ Other _____
- ☐ Family History of Reaction to Anesthesia
- ☐ Family History of Stroke
- ☐ Family History of Ulcerative Colitis

Past Surgical History

Please Complete as accurately as possible

- ☐ NO PAST SURGERIES
- ☐ Ankle Surgery ☐ Left ☐ Right
- ☐ Appendectomy
- ☐ Arm Surgery ☐ Left ☐ Right
- ☐ Back Surgery
- ☐ Breast Surgery ☐ Left ☐ Right
- ☐ Calf Surgery ☐ Left ☐ Right
- ☐ Carpal Tunnel Surgery ☐ Left ☐ Right
- ☐ Clavicle Surgery ☐ Left ☐ Right
- ☐ Colon Surgery
- ☐ Ear/Nose/Throat Surgery
- ☐ Elbow Surgery ☐ Left ☐ Right
- ☐ Eye Surgery ☐ Left ☐ Right
- ☐ Finger Surgery ☐ Left ☐ Right
- ☐ Foot Surgery ☐ Left ☐ Right
- ☐ Gallbladder Surgery
- ☐ Hand Surgery ☐ Left ☐ Right
- ☐ Head Surgery
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Hip Replacement Surgery ☐ Left ☐ Right
- ☐ Hip Surgery ☐ Left ☐ Right
- ☐ Hysterectomy
- ☐ Knee Replacement Surgery ☐ Left ☐ Right
- ☐ Knee Surgery ☐ Left ☐ Right
- ☐ Lung Surgery
- ☐ Neck Surgery
- ☐ Neuro Surgery
- ☐ Reproductive Surgery
- ☐ Shoulder Replacement Surgery ☐ Left ☐ Right
- ☐ Shoulder Surgery ☐ Left ☐ Right
- ☐ Skin Surgery
- ☐ Spine Surgery
- ☐ Stomach Surgery
- ☐ Thigh Surgery ☐ Left ☐ Right
- ☐ Thyroid Surgery
- ☐ Toe (S) Surgery ☐ Left ☐ Right
- ☐ Tonsillectomy
- ☐ Urology Surgery
- ☐ Vascular Surgery
- ☐ Wrist Surgery ☐ Left ☐ Right
- ☐ Other: Explain_____

Social History

Substance Use

- ☐ Alcohol Amt_____ How long_____
- ☐ Illegal Substance Use
- ☐ Prescription Drug Abuse
- ☐ Tobacco Amt_____ How long_____
- ☐ NONE

Exercise

- ☐ Active but no Formal Exercise
- ☐ Heavy (4 or more times weekly)
- ☐ Minimal (Once or less a week)
- ☐ Moderate (1-3 times weekly)
- ☐ Sedentary
- ☐ NONE

Education Level

- ☐ Elementary
- ☐ High School
- ☐ College
- ☐ Graduate School

Marital Status

- ☐ Common Law Marriage
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ Other_____

Work Status

- ☐ Disable
- ☐ Homemaker
- ☐ On Leave
- ☐ Retired
- ☐ Student
- ☐ Unemployed
- ☐ Working Full Time Occupation_____
- ☐ Working Part Time Occupation_____
- ☐ Other _____

MEDICATION LIST

Patient Name: _____ Todays Date:_____
Date of Birth: _____

Pharmacy: _____ Pharmacy number: _____

ALLERGIES: Please list all allergies or sensitivities to medications below

☐ **NO KNOWN DRUG ALLERGIES**

ALLERGIC TO: **Latex** ☐ Yes ☐ No **Iodine** ☐ Yes ☐ No **ShellFish** ☐ Yes ☐ No **Contrast** ☐ Yes ☐ No **Food** ☐ Yes ☐ No

Allergies to Medications	Reaction

Medications: Please list all medications, supplements, vitamins, and other pills that you are currently taking.

☐ Not currently taking medication

Medication	Strength *Dose (MG)*	Quantity *# of pills*	Frequency *How Often*	Indication *Reason*	Currently *Taking Y/N*

Review of Systems

Pt. Name: Date of Birth:

Constitutional:
☐ Fever ☐ Chills ☐ Nausea ☐ None of these

Eyes:
☐ Changes in Vision ☐ Blurred Vision ☐ Blindness ☐ None of these

HENT:
☐ Hearing loss/Changes ☐ Vertigo ☐ Difficulty Swallowing ☐ None of these

Cardiovascular:
☐ Chest Pain ☐ Irregular Heartbeat ☐ Edema ☐ None of these

Respiratory:
☐ Shortness of Breath ☐ Sleep Apnea ☐ Chronic Cough ☐ None of these

Gastrointestinal:
☐ Bowel Changes or Problems ☐ Abdominal Pain ☐ Heart Burn ☐ None of these

Genitourinary:
☐ Difficulty Voiding ☐ Urgency ☐ Frequency ☐ None of these

Integument:
☐ Pigmentation Changes ☐ Rash ☐ Itching ☐ None of these

Neurological:
☐ Headaches ☐ Tremors ☐ Speech Difficulties
☐ Tingling or numbness ☐ Change in Gait/Balance ☐ Seizures ☐ None of these

Musculoskeletal:
☐ Joint Pain ☐ Joint Swelling ☐ Joint Stiffness
☐ Leg Pain when walking ☐ Muscle Pain ☐ Muscular Weakness ☐ None of these

Endocrine:
☐ Weight Loss ☐ Weight Gain ☐ Loss of Hair ☐ None of these

Psychiatric:
☐ Anxiety ☐ Depression ☐ Feeling Confused ☐ None of these

Heme-Lymph:
☐ Easy Bruising
☐ Easy Bleeding ☐ Lymph Node enlargement or tenderness ☐ None of these

Allergic-Immunologic:
☐ Sinus Allergy Symptoms
☐ Frequent Illness ☐ Allergic Dermatitis ☐ Frequent Illness ☐ None of these

The Carrell Clinic

9301 N. Central Expressway Suite 400 • (P) 214-220-2468 • (F) 469-232-9738

Patient Consent to Treatment- I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such diagnostic, medical and/or office-based surgical treatment under the general and specific instructions of the physicians of The Carrell Clinic, their assistants or their designee as is necessary in their judgment.

Disclosure of Physician's Ownerships Interest North Central Surgical Center- Due to your physician's concern over improving the quality of healthcare and reducing cost of medical procedures. Along a with a number of other physicians, he has invested in North Central Surgical Center located at 9301 N. Central Expressway, Dallas TX 75231. After meeting with physician, if surgery is necessary, your physician may schedule your surgery at NCSC. Your physician's ownership interest in NCSC mans that your physicians may benefit from choosing to perform surgical procedures at NCSC. Because of this, your physician herby advises you that you have the right to choose to be treated at a different facility, should you desire, and he will make such arrangement, if possible. North Central Surgical Center is a separate legal entity from W.B. Carrell Memorial Clinic. You will receive a separate billing from each entity.

Medication Policy- The following guidelines are intended for your safety and meeting your medication needs in an efficient manner.

- Take medication only as prescribed
- We do not prescribe long term medications, patients requiring long term pain mediation will be referred to a pain management specialist.

Refills

- Call your pharmacy directly for medication refills
- Instruct pharmacy to fax all request to 214-750-1982
- Choose only one pharmacy for all of your medications
- Allow three business days for medication refills
- Early refills will not be honored for any reason

To protect your health: Notify our office of all medication changes by other physicians, as this can be potentially dangerous situation. Lost, stolen, or misplaced medications are replaced only with a clinic visit.

Formulary Benefits Data Consent Form- Formulary Benefits data are maintained for health insurance providers by organizations knowns as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibility are processing and paying prescriptions drug claims. They also develop and maintain formularies, which are list of dispensable drugs covered by a particular drug benefit plan. We may need access to your data as maintained by PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan. This consent will enable W.B. Carrell Clinic to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with a preference rank (if available) within drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by another provider.

_____ _____

Patient Name (printed) **Date of Birth**

_____ _____

Patient/Guardian Signature **Date**

The Carrell Clinic

9301 N. Central Expressway, Suite 500
Dallas, Texas 75231
214-220-2468

Patient Authorization for use and Disclosure of Protected Health Information

I authorize W.B. Carrell Clinic to disclose certain protected health information (PHI) about me to (EX: Wife, doctor, children, etc…). Please list name, number and their relationship.

First and Last Name	Phone Number	Relationship
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

This authorization allows The Carrell Clinic to discuss **my treatment** and **care** for (pick one)

- o Any and All conditions
- o Only the specific condition listed:_____

This Authorization will expire on: _____ (expiration date or defined event)

- o No expiration

I understand that I have the right to revoke this authorization at any given time, to the extent that W.B. Carrell Clinic has not taken action on it, by putting the revocation in writing and signing and dating.

_____ _____
Patient's Name Date Patient's Date of Birth

_____ _____
Patient's/ Authorized signature Relationship to patient (if minor)

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Financial Policy

We are dedicated to providing the best possible care to you and regard your understanding of our financial policies an essential element of your care and treatment. The Carrell Clinic financial policy is intended to clarify these issues.

- Please present your insurance card at each appointment along with photo identification.
- Your insurance policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, they may not pay for all or part of your care, and you may not qualify for any managed care discounts. If your insurance company does not pay within 60 days of the date of service, you may be expected to pay the balance in full.
- Self-pay patients: Payment is due at the time service is rendered unless other arrangements have been made in advance. For your convenience, we accept cash, check (in state only), VISA, Master Card, Discover and American Express. You may also pay your bill on-line at www.wbcarrellclinic.com
- Responsibilities for payments who are minor children, whose parents are divorced, rest with the parent who seeks the treatment (This parent is the guarantor). Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of The Carrell Clinic.
- We will bill participating insurance companies as a courtesy to you. We do require that payment of deductible, co-pays and co-insurance be paid at the time of service.
- We do not bill third party insurance companies such as: Auto or Liability Insurance; therefore, payment is expected in full at the time of service. However, we will provide you with the necessary paperwork and forms to help you submit your claim to the appropriate insurance carrier.
- Some orthopedic supplies are not covered by your insurance; These must be paid at the time of service
- Patients with an outstanding balance 60 days or more overdue must make payment arrangements prior to scheduling appointments.
- Appointment Cancellations within 24 hours of the scheduled time may result in a $45.00 charge.
- Returned checks for any reason will result in a $35.00 charge to your account.
- The Carrell Clinic Billing Coordinators are available to help you with your billing questions Monday through Friday between 8:30am and 5:00pm by calling 214-220-2468.

I / we assign to Medical Staff Physician, and Health care providers, and authorized direct payment to Facility(s) all insurance benefits or Medicare benefits which may be entitled. This assignment includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I / we agree to pay Facility (s) for any and all charges not paid pursuant to this assignment.

I have read and understand The Carrell Clinic Financial Policy and agree to abide by its guidelines.

_____
Print Patient Name

_____ Date _____
Signature of Patient / Parent / Legal Representative

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HIPAA Privacy Practice

This notice describes how health 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 The Carrell Clinic at (214) 220-2468.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information.
For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. 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 cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements.

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

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. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/ discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

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 activities.

- These activities generally include the following:
- To prevent or control disease, injury or disability.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government 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. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our facility
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial.

The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that 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 for as long as we keep the information. To request an amendment, your request must be made in writing and must be contained on one page of paper legibly handwritten or typed in at least 10-point font size. In addition, you must provide a reason that supports your request for an amendment.

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

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information, which you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. 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. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

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 your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health 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 a post office box.

To request confidential communications, you must make your request in writing. 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 obtain a paper copy of this notice at any time. To obtain a copy, please request if from the front office staff

You may also obtain a copy of this notice at our Web site, **www.wbcarrellclinic.com**. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request.

If the first service delivery is delivered electronically, other than by telephone, we provide electronic notice in the same medium, automatically and contemporaneously in response to a first request for service.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact The Carrell Clinic. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

I have read and understand the above HIPAA Privacy Practice. If you choose, or are not able to sign, a staff member will sign their name, date. THIS ACKNOWLEDGEMENT WILL BE PLACED IN YOUR RECORD

Print Patient Name	Signature of Patient / Parent / Legal Representative	Date