DENTAL PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name	**Gender Pronoun** ☐ He/His ☐ She/Hers ☐ They/them	**Gender Identity** ☐ M ☐ F ☐ Transgender (M to F) ☐ Transgender (F to M)	**Sexual Orientation**

Social Security	**Date of Birth (MM/DD/YY)**	**Assigned Sex at Birth** ☐ M ☐ F	
Primary Address	**City**	**State**	**ZIP**
Email Address	**Primary Phone**	**Secondary Phone**	
How did you hear about us?	**Language Preference**	**Interpreter Needed?** ☐ Yes ☐ No	

Please select your preferred pharmacy
☐ TH Sanford ☐ TH Southside ☐ TH Lake Underhill ☐ TH Hoffner ☐ TH Alafaya
☐ Other (Include Name and Address) _____

Preferred Contact Method
☐ Mail ☐ Primary Phone ☐ Secondary Phone
☐ Patient Portal

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Separated	**Family Size**	**Household Income**

Race/Ethnicity – Select all that apply.
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other
Are you Hispanic? ☐ Yes ☐ No

Please check if the following apply to you
☐ I am currently uninsured ☐ Refugee
☐ Agricultural Worker ☐ Homeless ☐ Veteran
☐ Public Housing ☐ Citizen ☐ School-based

As an FQHC, we have several resources available to you. Please indicate if you are encountering the following barriers to your care?
☐ Financial ☐ Limited English Proficiency ☐ Physical/Mobility ☐ Geographical Location ☐ Access to Care ☐ Digital Access
☐ Transportation ☐ Food Shortage ☐ Education ☐ Cultural ☐ Housing ☐ Childcare ☐ Language ☐ Internally Displaced

Emergency Contact Name	**Relationship to Patient**	**Emergency Contact Phone**

INSURANCE & GUARANTOR INFORMATION

Primary Insurance	**Policy #**	**Group #**
Payer Address (located on the back of the card)		
Subscriber Name	**Relationship to Patient**	
Secondary Insurance (if applicable)	**Policy #**	**Group #**
Secondary Payer Address (located on the back of the card)		
Subscriber Name	**Relationship to Patient**	
Guarantor/Name of Person Responsible for Payment (if different from Subscriber)		

Address	**City**	**State**	**ZIP**
Phone	**Relationship to Patient**		

Patient/Guarantor Signature	**Date**

DENTAL HEALTH HISTORY

Patient Name	Date of Birth (MM/DD/YY)

Do you currently have or have you had any of the following:			
Rheumatic fever or Heart Murmur	☐ Yes ☐ No	Emotional Problems	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No	Neurological Problems	☐ Yes ☐ No
High or Low Blood Pressure	☐ Yes ☐ No	Tuberculosis (TB) or Persistent cough	☐ Yes ☐ No
Fainting or Dizzy Spells	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Anemia or Blood Problems	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Sickle Cell Anemia	☐ Yes ☐ No	Liver Problems or Hepatitis	☐ Yes ☐ No
Excessive Bleeding or Bruise Easily	☐ Yes ☐ No	Attention Deficit Disorder (ADD)	☐ Yes ☐ No
Blood Transfusions	☐ Yes ☐ No	Hyperactivity Disorder	☐ Yes ☐ No
Allergies or Skin Rash	☐ Yes ☐ No	AIDS or HIV Positive	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Pregnancy (Trimester: ☐ 1 ☐ 2 ☐ 3)	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No		
Cancer (Type: _____)	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No

Are you currently under the care of a physician? If yes, list name of doctor: _____	☐ Yes ☐ No
Have you been hospitalized in the last 2 years? If yes, why? _____	☐ Yes ☐ No
Are you currently taking any medications, pills, or drugs? If yes, list: _____	☐ Yes ☐ No
Are you allergic to or have you ever experienced any ill effect from a local anesthetic (Novocaine), Penicillin, or any drug/pills? (i.e. rash, itching, or fainting) If yes, describe: _____	☐ Yes ☐ No
Have you ever experienced any unfavorable reaction from previous dental treatment? If yes, describe: _____	☐ Yes ☐ No
Are you currently having any dental pain or problem? If yes, describe: _____	☐ Yes ☐ No

Acknowledgement

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors that I may have made in the completion of this form. I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Patient/Guardian Signature	Relationship to Patient	Date

DENTAL TREATMENT INFORMATION

Patient Name	Date of Birth (MM/DD/YY)

Dental treatment we offer consists of diagnostic services (examination, x-rays), preventive services (teeth cleaning, fluoride application, sealants, and oral hygiene instructions), corrective restorative services (white fillings, silver crowns), and endodontic services (pulpotomies), usually performed using local anesthetic.

The specific services you need and the availability of these services through this dental program will be explained to you by the dental staff. The services recommended to you are needed to improve and maintain your teeth and supporting structures (gums and bone). Good oral health is needed for eating, speaking, and appearance. Some dental infections may become life-threatening. If you decide to have the recommended treatment, this does not guarantee success nor does it guarantee that problems will not occur. Success of the treatment also depends on following the home care instructions given to you by the dental staff. Each individual case, however, is unpredictable; your condition may be the same, better, or worse after treatment.

Routine dental treatment has very few risks; they occur rarely and are usually mild. However, you should be aware of these risks, including (but not limited to) complications resulting from the use of dental instruments, drugs (i.e. antibiotic and pain medicine), and local anesthetic. Possible complications include: swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation on the lip, tongue, chin, gums, cheeks, and/or teeth, which is usually temporary but on infrequent occasions may be permanent; chewing injury to the lips and/or tongue after the use of local anesthetic; allergic reaction to any drugs or anesthetic used; change in occlusion (biting); jaw muscle cramps and spasm; temporomandibular (jaw) joint difficulty; loosening of teeth; nausea and vomiting; delayed healing; sinus perforation; and/or treatment failure.

If a complication occurs, additional treatment may be needed. This additional treatment may not be available through True Health. If treatment is not available through this organization, True Health is not financially responsible for the treatment cost associated with taking care of the complication.

It is your responsibility to ask questions about any comments on this sheet that you do not understand so they can be explained to your satisfaction.

Consent for Dental Services – Please initial the statements below.

_____ I certify that I have read and understand the information above.

_____ I authorize and consent to having this procedure performed on the patient indicated at the top of this form by the provider and whomever he or she may designate.

_____ I understand that I may withdraw this consent at any time, in written form.

Patient/Guardian Signature	Relationship to Patient	Date
Employee Signature		**Date**

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Sliding Fee Scale Agreement

Patient Name	Date of Birth (MM/DD/YY)

All patients may qualify for the sliding fee scale discount program at True Health. Eligibility for the sliding fee scale discount program is based on household income and family size. We require documentation to determine eligibility.True Health reserves the right to review your tax return and/or wage statements upon request. Eligibility will be updated periodically depending on the type of documentation provided. If there are any changes in your income status or insurance eligibility prior to your scheduled update, please notify True Health immediately.

Please initial each statement in the space provided.

_____ *(initials)* I certify that the income and family information supplied on this form is true and correct to the best of my knowledge. I understand that if any of the information provided in this form has been falsified, this agreement will be canceled, and I will be responsible for the **FULL** cost of services. I understand this document will be maintained in my permanent medical record and that falsification of information may constitute a federal offense.

_____ *(initials)* I understand that the sliding fee scale is subject to change. I understand fees are subject to change depending on the level of service and/or procedures performed during the visit.

_____ *(initials)* I understand that payment is expected upon receipt of services.

_____ *(initials)* (If applicable) I have been informed and understand that if I do not supply proof of my income at my next visit, my category will be changed to a higher fee scale.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only

Proof of Income	Gross Amount (including Cents)									Monthly Total
Weekly Paystubs/Employer Letter (letterhead)	$	+	$	+	$	+	$	=	$	
Bi-weekly Paystubs/Employer Letter (letterhead)	$			+	$			=	$	
Paystub Average Calculation (4 weekly/2 bi-weekly)	$			/				=	$	
Social Security Award Letter	$							=	$	
Last year's Income Tax Return (W-2 and/or schedules attached)	$							=	$	
Unemployment Compensation Statement	$							=	$	
Notarized Letter of Support	$							=	$	

Please check if applicable

☐ No proof of income presented	☐ School Enrollment	☐ Self-Declaration Form

Annual Income Calculation (monthly x12,26,52 depending on frequency of income)	

Annual income $_____. Family size _____. Sliding Fee Schedule Expiration Date _____

Please select the appropriate slide	☐ Slide A ☐ Slide B ☐ Slide C ☐ Slide D ☐ Slide E ☐ Slide F

Employee Name (printed)	Date

Authorization and Agreement for Treatment

Patient Name	Date of Birth (MM/DD/YY)

The undersigned hereby makes the acknowledgements and agreements regarding the treatment to be provided to the patient whose name appears on the Registration Form. The patient, guardian, or patient representative must initial all applicable items.

Consent for Treatment

_____ *(initials)* I certify that I am requesting examination and medical treatment of the patient by the physicians and employees of True Health via face-to-face visit and/or telehealth services. I give permission for evaluation and treatment and certify that no guarantee or assurance has been made as to the results that may be obtained. If the patient is a minor, I understand that a parent, legal guardian, or responsible adult must accompany the patient to the health center and stay with the patient throughout the entire examination.

Financial Agreement and Assignment of Benefits

_____ *(initials)* I acknowledge that I have received a copy of the True Health Financial Policy and that I agree to abide by its terms.

Patient's Bill of Rights and Responsibilities

_____ *(initials)* I acknowledge that I have received a copy of the True Health Patient's Bill of Rights and Responsibilities and that I agree to abide by its terms.

Notice of Privacy Practices

_____ *(initials)* I acknowledge that I have received a copy of True Health's Notice of Privacy Practices.

Release of Medical Information

_____ *(initials)* (If applicable) In addition to the use and/or disclosure of my protected health information (PHI) as stated above, I authorize my information to be released to the following individual(s). Please provide full name(s) of authorized individual(s) below. I understand that this request will not restrict the normal use or disclosure of PHI as stated above.

Name of Authorized Person	Relationship to Patient

_____ *(initials)* I understand that I may amend or revoke my consent to use and/or disclosure of PHI at any time, if submitted in writing. Use or disclosure that occurs prior to the date on which the revocation of consent is received will not be affected.

I have read and fully understand the above acknowledgments and agreements.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only		
Employee Signature	**Employee Title**	**Date**

FINANCIAL POLICY

True Health provides high-quality, comprehensive healthcare at a reasonable cost to everyone.

FINANCIAL RESPONSIBILITY: Patients are financially responsible to True Health for 100% of the charges for professional services provided. True Health accepts all major credit cards, personal checks, money orders, and cash. True Health works with patients to make sure their medical care does not become a financial burden, including offering payment plans.

To bill the patient's insurance, True Health needs complete and accurate information about the patient's, primary, secondary, and any supplementary insurance companies, including phone numbers, addresses, and a copy of the insurance card. Without this information, the patient may be required to pay in full at the time of service. True Health may verify insurance at any time to get preauthorization or check eligibility. Patients are expected to pay co-pays and deductibles at the time of service and must inform True Health of any changes in their insurance. Any unpaid balances or denied claims due to incomplete information are the patient's responsibility.

REFUSAL TO PAY: As stated in the Patient's Rights and Responsibilities, patients are expected to pay their medical bills without delay. True Health recognizes that a patient may have the inability to pay for their visit. True Health defines this as not having the resources to pay for the visit, due to documented hardships like homelessness or financial barriers.

True Health defines refusal to pay as the patient choosing not to pay their bills or follow a payment plan offered by True Health. A delinquent account means having a balance for 60 days or more, with no payments made towards the balance, or a balance of $1,000 with no payment plan scheduled. If True Health determines a patient can pay but refuses, True Health may reschedule the appointment until the patient makes a payment. If the patient believes they are unable to pay, a front desk team member will review options with them.

SLIDING FEE SCALE PROGRAM: Patients may qualify for a sliding fee scale discount based on household income and family size. Services are not denied due to inability to pay. To qualify, patients need to provide a photo ID and at least one form of income verification from the list below.

- Most recent and consecutive paycheck stubs (2 if paid bi-weekly, 4 if paid weekly).
- Unemployment compensation statement.
- Social Security benefits determination.
- The previous year's income tax return (including 1040 or W-2/1099).
- A typed, notarized statement of income from the employer or verification of other support.

If a patient has no income or is receiving temporary assistance, a self-declaration form may be used after counseling with the Center Manager/Office Supervisor. Additional fees apply for labs and other services during the visit. If the patient does not provide the required documents to qualify for the reduced-rate services according to the federal guidelines, the patient will be expected to pay the full price.

MEDICAID: True Health accepts Medicaid and bills it directly. Payments go directly to True Health.

MEDICARE: True Health accepts Medicare and bills it and supplementary insurance directly. Being a Federally Qualified Health Center, the Medicare deductible may be reduced for True Heath services.

CONTRACTED INSURANCE: True Health contracts with insurance companies and payments go directly to True Health. Patients must pay co-pays and deductibles. If services are non-covered or deemed medically unnecessary by the insurance company, the patient is responsible for those charges. Unpaid balances are due within 30 days after the insurance payment.

PRIMARY CARE PROVIDER SELECTION: If a patient's insurance plan requires a Primary Care Provider (PCP) to be listed to receive primary care services, the patient must ensure True Health is listed as the PCP. A front desk team member can help with this. If this change is not made before the scheduled appointment time, the appointment may be postponed or rescheduled.

WORKER'S COMPENSATION: True Health does not accept worker's compensation cases. Patients should contact their employer for guidance.

NON-CONTRACTED INSURANCE: Patients with non-contracted insurance must pay for all office visits at the time of service. These fees are based on the Medicare fee schedule. A patient may choose to enroll in the Sliding Fee Program. Referrals by True Health providers may not be accepted by the patient's insurance company.

Acknowledgment of Financial Policy: By signing below, the patient acknowledges:

- They have received a copy of the True Health Financial Policy.
- They understand and agree to its terms.
- They agree to pay all charges for care and treatment, including co-payments and deductibles.
- Benefits paid by a third party will be credited to the patient's account.
- They are responsible for the account balance, regardless of insurance status.
- If they do not make timely payments and are not classified as unable to pay, True Health may reschedule their visit until a contribution is made.

Once signed, the agreement is in full force and effect. Acknowledgment of this policy is necessary to receive services by True Health.

Patient/Guardian Name	**Patient/Guardian Signature**	**Date**

Patient's Bill of Rights and Responsibilities

True Health believes the Patient's Bill of Rights and Responsibilities will contribute to more effective patient care. True Health recognizes service providers and clinical staff have certain responsibilities toward the patient and the patient has certain rights and responsibilities toward True Health.

Patient's Rights

1. *Information Disclosure:* Patients have the right to receive accurate and easily understood information to make informed decisions about their health plans and medical providers. Patients have the right to be informed of services available and their respective fees, as well as related charges for non-covered services for which the patient will be responsible. Patients have the right to be informed of the accreditation status of the health center, certification and years of practice of the medical providers, results of patient satisfaction surveys and quality of care studies, and complaints and appeal processes. Patients have the right to be informed about the organization's rules and regulations that apply to them. Patients have the right to be informed of any existing or potential relationship between True Health and other health/educational agencies or individuals participating in their health care.
2. *Choice of Providers and Plans:* Patients have the right to choose their healthcare provider to ensure access to high quality medical care. Patients have the right to access qualified specialists through our referral network. Patients have the right to choose health plans.
3. *Access to Emergency Services:* Patients have the right to access emergency services when and where the need arises. The health center will inform patients of the provisions for after-hours access to the medical providers and emergency coverage.
4. *Participation in Treatment Decisions:* Patients have the right to be informed by their medical provider of their diagnosis, treatment, and prognosis in easily understood terms; to be offered the opportunity to participate in planning their medical treatment and any specialist referrals; and to refuse participation in experimental research. Patients have the right to give informed consent prior to procedures.
5. *Respect and Non-Discrimination:* Patients have the right to be treated with consideration, respect, and full recognition of their dignity and individuality; to be free from mental and physical abuse; and to be free from physical restraints except as authorized in writing by a medical provider for a specific and limited period of time, or when necessary to protect the patient from injury to themselves or others. Patients have the right to receive the best available medical care regardless of age, sex, race, color, religion, language, economic status, disability, sexual orientation, or national origin.
6. *Confidentiality:* Patients have the right to privacy and confidentiality in all interactions with staff members and in their medical records. Medical records will only be released to other individuals or organizations with the patient's consent, except in cases required by law or third-party payment contracts.
7. *Complaints and Appeals:* Patients have the right to a fair and efficient process for resolving differences with their medical providers or True Health staff free from restraint, interference, coercion, discrimination, or reprisal. Complaints may be presented in person or in writing. Complaints that are clinical in nature will be handled by the Clinical Manager and/or Lead on site. Complaints concerning the pharmacy will be handled by the Pharmacist in charge. Complaints concerning the clerical or demographic staff will be handled by the Center Manager or Office Coordinator. A follow-up response will be given to the patient in a timely manner, either in person or via phone or written communication, from the Patient Service Coordinator or appropriate Director.
8. Patients have the right to receive information to assist them in preparing a document called an "Advance Directive." Patients have a right to have this Directive included in their electronic health record and any appropriate record releases per the patient's signed consent. True Health does not honor DNR (Do Not Resuscitate) Orders.

Patient's Responsibilities

1. Patients have the responsibility to follow the organization's rules and regulations.
2. Patients have the responsibility to report any changes in their medical condition.
3. Patients have the responsibility to let their medical provider know if they do not understand any aspect of their medical care.
4. Patients have the responsibility to participate in the decision-making processes regarding their medical care and to follow the treatment plans set up for them. This includes keeping appointments and/or cancelling in advance when necessary.
5. Patients have the responsibility to give truthful financial information, and to pay their bills in a timely manner.
6. Patients have the responsibility to advise us if they are dissatisfied with their care.
7. Patients have the responsibility to treat other patients and our staff with respect, consideration, and full recognition of their dignity and individuality.
8. Patients have the responsibility to respect and care for True Health property and facilities.

Patient-Centered Medical Home (PCMH)

The medical home encompasses five functions and attributes:

1. Comprehensive Care

The patient-centered medical home is accountable for meeting:

- A majority of each patient's physical and mental health care needs
- Prevention and wellness
- Acute care
- Chronic care

Providing comprehensive care requires a team of care providers. This team might include physicians, physician assistants, nurses, pharmacists, and care coordinators.

2. Patient-Centered

The patient-centered medical home provides health care that is relationship-based with an orientation toward the whole person.

- Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences.
- The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses.
- Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

3. Coordinated Care

- The patient-centered medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports.
- Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.
- Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

4. Accessible Services

The patient-centered medical home delivers accessible services with shorter waiting times for:

- Urgent needs
- Enhanced in-person hours
- Around-the-clock telephone or electronic access to a member of the care team
- Alternative methods of communication such as email and telephone care.

The medical home practice is responsive to patients' preferences regarding access.

5. Quality and Safety

The patient-centered medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as:

- Using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families
- Engaging in performance measurement and improvement
- Measuring and responding to patient experiences and patient satisfaction
- Practicing population health management

Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

Patient/Guardian Signature _____ Date _____

Visitation Consent

Patient/Guarantor Name	Date of Birth (MM/DD/YYYY)

I _____ hereby understand and acknowledge True Health's discretion regarding the number of individuals allowed in all patient care areas. I understand True Health can limit the number of individuals allowed in all patient care areas without prior notification of my visit.

I authorize the following individuals/entities to be present during my medical care at True Health:

1) Medical Students
2) Visiting Physicians
3) Health care industry representatives
4) Surveyors
5) Maintenance workers
6) Vendors
7) All other individuals/organizations as deemed relevant and/or medically necessary by True Health and/or its authorized partner organizations.

Additionally, I authorize True Health to revise the individuals/entities at any time prior to any visit.

I have read and fully understand the above acknowledgment and agreement.

Patient/Guarantor Signature	Relationship to Patient	Date

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Visit Acknowledgment Form

Patient Name	Date of Birth (MM/DD/YY)

As part of True Health's effort to provide a safe environment for both patients and staff, we ask that you follow the terms as listed below:

1) Restrict cell phone usage as follows:
    a. During the clinical portion of the visit, no cell phone usage will be permitted.
    b. No video chatting, photography, or recording will be permitted during the entire visit.
    c. While in the waiting room, please utilize headphones for all electronic devices.
    d. If a guest needs to complete a call during the clinical portion of the visit, they will return to the reception area.
2) No eating and/or drinking for the duration of the visit
3) Restrict the number of individuals:
    a. One adult guest per patient in the exam room
    b. No unsupervised children left in the waiting room

Please note that a failure to follow these terms may result in your visit being rescheduled at a later date. Your signature below acknowledges that you will follow the instructions listed above.

Patient/Guardian Signature	Date

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Notice of Privacy

HIPAA Officer: Christina Iliff
(407) 322-8645 ext. 1149
Chrisitna.Iliff@mytruehealth.org
4930 E. Lake Mary Blvd.
Sanford, FL 32771

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

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

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

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

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

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing the spread of communicable disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing serious threat to yourself and/or others' health and safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

HIPAA Officer: Christina Iliff • (407)322-8645 ext. 1149 • Christina.Iliff@mytruehealth.org