ENT & FACIAL PLASTIC™ SURGERY SPECIALISTS OF SHADY GROVE

Medical History Form

Patient Name: _____ Date of Birth: _____

EARS

Ear Pain	○ Yes	○ No
Ear Pressure	○ Yes	○ No
Ear Itchiness	○ Yes	○ No
Dizziness	○ Yes	○ No
Ringing in Ears	○ Yes	○ No
Discharge	○ Yes	○ No
Noise Exposure	○ Yes	○ No
Hearing Loss	○ Yes	○ No
Lightheadedness	○ Yes	○ No

NOSE

Injury	○ Yes	○ No
Surgery	○ Yes	○ No
Blockage	○ Yes	○ No
Headache	○ Yes	○ No
Post Nasal Drip	○ Yes	○ No
Discharge	○ Yes	○ No
Bleeding	○ Yes	○ No
Snoring	○ Yes	○ No
Unable to Smell	○ Yes	○ No
Sinusitis	○ Yes	○ No
Sleep Apnea	○ Yes	○ No
Using CPAP?	○ Yes	○ No

THROAT

Soreness	○ Yes	○ No
Difficulty Swallowing	○ Yes	○ No
Painful Swallowing	○ Yes	○ No
Lump in Throat	○ Yes	○ No
Hoarseness/Change in Voice	○ Yes	○ No
Throat Clearing	○ Yes	○ No

ALLERGY

Hayfever	○ Yes	○ No
Asthma	○ Yes	○ No
Skin Test	○ Yes	○ No
Allergy Shots	○ Yes	○ No

EYES

Watery Eyes	○ Yes	○ No
Blind Spots	○ Yes	○ No
Light Sensitive	○ Yes	○ No
Blurry/Visual Los	○ Yes	○ No
Glasses/Contacts	○ Yes	○ No
Cataracts	○ Yes	○ No
Dry Eyes	○ Yes	○ No

CARDIOLOGY

Chest Pain	○ Yes	○ No
High Blood Pressure	○ Yes	○ No

ENT & FACIAL PLASTIC™ SURGERY SPECIALISTS OF SHADY GROVE

Patient Name: _____

Date of Birth: _____

RESPIRATORY

Cough	○ Yes	○ No
Pneumonia	○ Yes	○ No
Shortness of Breath	○ Yes	○ No

NEUROLOGY

Stroke	○ Yes	○ No
Weakness	○ Yes	○ No
Headache	○ Yes	○ No
Seizures	○ Yes	○ No

HEMATOLOGY/LYMPH

Bruising	○ Yes	○ No
Bleeding	○ Yes	○ No
Plavix usage?	○ Yes	○ No
Coumadin usage?	○ Yes	○ No
Aspirin usage?	○ Yes	○ No
NSAID usage?	○ Yes	○ No
Clotting problems	○ Yes	○ No

CONSTITUTIONAL

Fever	○ Yes	○ No
Weight Loss	○ Yes	○ No
Fatigue	○ Yes	○ No

GASTROENTEROLOGY

Constipation	○ Yes	○ No
Nausea	○ Yes	○ No
Abdominal Pain	○ Yes	○ No
Heartburn	○ Yes	○ No
Blood in Stool	○ Yes	○ No
Regurgitation	○ Yes	○ No
Vomiting	○ Yes	○ No
Diarrhea	○ Yes	○ No

MUSCULOSKELETAL

Aches	○ Yes	○ No
Weakness	○ Yes	○ No
Arthritis	○ Yes	○ No

FAMILY HISTORY

FATHER	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes
MOTHER	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes
SIBLINGS	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes
CHILDREN	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes

ENT & FACIAL PLASTIC™ SURGERY SPECIALISTS OF SHADY GROVE

Patient Name: _____

Date of Birth: _____

SOCIAL HISTORY

Martial Status:	○ Married	○ Single	○ Divorced	○ Widowed
Occupation:	○ Full time	○ Part time	○ Retired	○ Homemaker
	○ Student	○ Unemployed		
Smoking:	○ Yes	○ No	○ Trying to Quit	
Alcohol:	○ Yes	○ No	○ Social drinker	
	○ Trying to Quit	○ Recovering Alcoholic		
Recreational Drugs:	○ Yes	○ No		
HIV Infected:	○ Yes	○ No	○ Status Unknown	

MEDICAL HISTORY

(Please **CIRCLE** any of the conditions that may relate to you **currently**)

Diabetic	Hyperthyroidism	Asthma	High Blood Pressure
Cardiac Patient	Hypothyroidism	Breastfeeding	Antibiotics Prior To Dental
MAO Inhibitor	Renal Failure	Pregnant	
Recent Mono	Anticoagulants	Liver Disease	

Other Medical History: _____ Cancer: _____

ALLERGIES

Allergies To Medications: _____

☐ No Known Drug Allergies

LIST ALL CURRENT MEDICATIONS:

_____

_____

_____

LIST ALL PAST SURGERIES:

_____

_____

_____

ENT & FACIAL PLASTIC SURGERY SPECIALISTS
OF SHADY GROVE

PATIENT'S NAME (PLEASE PRINT) First, Middle, Last	SOCIAL SECURITY NUMBER	MARITAL STATUS	SEX	DATE OF BIRTH	AGE

HOME ADDRESS CITY, STATE, ZIP CODE	PRIMARY PHONE: SECONDARY PHONE:

RACE: American Indian/Alaska Native Indian ( ) Black-African American ( ) Asian ( ) White ( ) Native Hawaiin or other Pacific Islander ( ) Other Race ( )	ETHNICITY: Hispanic or Latin ( ) Not Hispanic ( )	LANGUAGE: English ( ) Spanish ( ) Other ( ) __

EMERGENCY CONTACT	RELATIONSHIP	HOME PHONE	CELL PHONE	BUSINESS PHONE

REFERRING PHYSICIAN	PRIMARY PHYSICIAN

PHARMACY NAME AND LOCATION

PATIENT EMAIL ADDRESS:

PRIMARY INSURANCE	POLICY ID NUMBER	GROUP NUMBER	EFFECTIVE DATE

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

EMPLOYER	OCCUPATION	BUSINESS PHONE EXT

SECONDARY INSURANCE	POLICY ID NUMBER	GROUP NUMBER	EFFECTIVE DATE

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

EMPLOYER	OCCUPATION	BUSINESS PHONE EXT

WERE YOU INJURED ON THE JOB? YES ☐ NO ☐	DATE OF INJURY	WORKMAN'S COMP CLAIM #	NAME, ADDRESS & PHONE OF LIABILITY INS.

ACCIDENT? YES ☐ NO ☐	AUTO ACCIDENT? STATE YES ☐ NO ☐	DATE OF ACCIDENT	NAME, ADDRESS, & PHONE OF ATTORNEY

How did you hear about us?

( ) Providers or Referral
( ) Friends or Family
( ) Internet
( ) Other _____

ENT & FACIAL PLASTIC SURGERY SPECIALISTS OF SHADY GROVE

Name:_____
DOB:_____

Consent for Treatment
Release of Information and Financial Responsibility

CONSENT FOR TREATMENT OF ONGOING MEDICAL CONDITION

I request and authorize ENT & Facial Plastic Surgery Specialists of Shady Grove ("Facility"), its agents and employees, my physicians, their associates, and assistants who may attend to me (collectively, the "Care Providers") to provide me health care services for the treatment which is advisable during the course of my evaluation, diagnosis, care, and treatment at Facility. Health care services may include but not be limited to things such as specific medical and surgical care, tests (including, but not limited to, tests to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS), procedures, drug administrations, and other services and supplies that are considered advisable by my physician for my health and wellbeing. I agree that this consent shall be continuing in nature during the entire course of my care, unless specifically revoked by me. I understand that I may be asked to sign a separate consent for the provision of health care services by Facility and/or Care Providers that require specific informed consent.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the Facility and Care Providers to share my personal health information with other people or organizations such as my insurance company and other physicians or health care providers as it relates to my treatment, payment for the care the Facility or treating physicians provide me and for other health care operations. Health care operations generally include those activities the Facility performs to improve the quality of care.

I authorize the Facility and Care providers of ENT & Facial Plastic Surgery Specialists of Shady Grove to contact me regarding my treatment in the following manner:

Leave a detailed message with the type of test(s) performed, test results and /or any other comments related to my health at:

(_____)_____(this is my □ cell □ home number □ work number)

In addition, the Facility has my permission to share my personal health information, including but not limited to test and procedure results with the following individuals:

_____ Spouse _____ Parents _____ None _____ other (please specify)_____

Name and phone number: _____

PRIVACY INFORMATION

The Facility has prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand the Facility's policies with regards to your personal health information. The terms of the Notice of Privacy Practices may change from time to time. As a result, the Facility will always post the most current notice at each facility site and on the Facility website in addition to making copies available for distribution. By signing this document, I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Name:_____
DOB:_____

ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby assign payments of insurance benefits for my account directly to the Facility and/or physicians working with the Facility for health care services rendered by the Facility and/or physicians. I understand the Facility accepts no liability for failure to meet any pre/post admission certification procedures required by my insurance carrier. I agree to pay the Facility and/or physicians providing service through the Facility for any of the charges not covered by insurance benefits at the prevailing or contractually agreed upon rates. Except as otherwise prohibited by State or Federal laws, I agree that I shall pay for all costs of collection, including reasonable attorney's fees, court costs, and all other expenses incurred by the Facility and/or physicians providing services through the Facility in enforcing its rights to payment of my account. I authorize the Facility or its agents to access my credit report in order to collect any charges due. If I provide the Facility or its agents with my cell phone number, I authorize the Facility or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts due. I understand that any email I provide is my personal email and I authorize the Facility or its agents to contact me via that email address. I further agree that any credit balances resulting from payment of insurance or other sources may be applied on any other account owed by me to the Facility and/or physician providing services.

I acknowledge that if my insurance requires me to have a referral, I am responsible for providing a referral at the time of my appointment. If I do not provide a referral, I understand that I will be considered “self-pay” and will be responsible for any charges for my appointment at the time of checking out.

PATIENT NOTICE OF OUT OF NETWORK REFERRALS

I acknowledge that a health care provider who does not contract with my health insurance company or participate in my health insurance plan's network (an "Out of Network Provider") may be called upon to render items or services during the course of my treatment, or I may receive a referral to obtain items and services from an Out of Network Provider. I understand that my health insurance plan may apply different coverage and payment limitations to items and services rendered by Out of Network Providers, and that I may contact my health insurance company for assistance, including identification of health care providers currently in my health insurance plan's network, prior to obtaining such items and services.

INTEREST AND MISSED APPOINTMENTS

Facility reserves the right to charge Interest on the unpaid principal balance, until paid in full, at a rate of 8% per annum should this bill not be paid within 30 (thirty) days of the statement date. I understand there is a charge of $35.00 for returned checks.

Furthermore, I understand that I may be charged a $100.00 fee for not keeping a scheduled appointment or failing to provide 24 hours’ notice of my inability to keep a scheduled appointment.

INDEPENDENT STATUS OF PHYSICIANS

I understand that physicians who furnish services to me will bill me for their services and collect independently for these services regardless of whether the physician is directly employed by the Facility. I understand that the physician bills provided to me will be separate and apart from the Facility's billing and collections.

PERSONAL PROPERTY

The Facility will not be responsible for my personal property.

COMMUNICATIONS

I agree to allow Facility, its medical providers, and its agents to contact me via the phone number I most recently provided to Facility or my physician in order to communicate with me regarding my medical treatment, including appointment reminders and confirmations and feedback regarding my treatment. I understand that I may be contacted using artificial or pre-recorded text, voice, or auto-dialer technologies and that I may incur network, data and other charges from my cellular provider. I acknowledge that text messages may contain limited information about me and my treatment and will not be encrypted and could be viewed by a third party with access to the transmission. I understand that I am not required to authorize these communications and that my agreement to receive such communications is not a condition or prerequisite for receiving medical treatment.

DISCRIMINATION

Facility complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We encourage patients to share information with their health care providers related to their race, color, national origin, age, disability, or sex, including gender identity, if that information would be helpful in ensuring the patient receives appropriate care.

Facility does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you believe that Facility has discriminated against you on the basis of race, color, national origin, age, disability, or sex, you can file a grievance at the Facility.

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

[SIGNATURE PAGE TO FOLLOW]

Name:_____
DOB:_____

By signing below, I acknowledge that I have read and understand the contents of this consent document.

_____
Patient Name (please print):

_____ Date:_____
Patient Signature

_____
Printed Name of Personal Representative (if applicable):

_____ Date:_____
Personal Representative Signature (if applicable)

Patient is a minor: ☐ Yes ☐ No

Please explain below if there is another reason why the patient is incapable of signing:

_____
_____

If the patient cannot read this form, a Witness or Translator should read the form out loud to the patient. The person who reads the form out loud should sign below as a Witness (if reading in English) or a Translator (if reading/translating the form into another language).

_____ Date:_____
Translator Signature (if applicable)

_____
Printed Name of Translator (if applicable)

ENT & FACIAL PLASTIC SURGERY SPECIALISTS
OF SHADY GROVE

NOTICE OF PRIVACY PRACTICES

Effective: June, 2022 Last Updated: June, 2022

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

This Notice of Privacy Practices ("Notice") describes how ENT & Facial Plastics Surgery Specialists, including its employees, staff, personnel, volunteers, and other professionals, will use and disclose your health records that are subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (your "Protected Health Information" or "PHI"). We understand that information about you and your health is personal. We are committed to protecting your personal health information. We create a record of the care and services you receive at ENT & Facial Plastic Surgery Specialists, which includes PHI. We need this record to provide you with quality care and to comply with certain legal requirements. By law, we are required to:

- maintain the privacy of PHI;
- provide you with this Notice of our legal duties and privacy practices with respect to your PHI; and
- abide by the terms of the Notice of HIPAA Privacy Practices currently in effect.

You may have additional rights under other applicable state or federal law. Applicable state or federal laws that provide greater privacy protection or broader privacy rights will continue to apply and we will comply with such laws to the extent they are applicable.

Uses or Disclosures of Your PHI

We access, use, and disclose PHI for a variety of reasons, as permitted or required by HIPAA. Other applicable laws governing sensitive information (including behavioral health information, drug and alcohol treatment information, and HIV status) may further limit these uses and disclosures. The following includes descriptions and examples of our potential uses and disclosures of your PHI. Please note that not every potential use and disclosure will be listed in this Notice, but all of the ways we may use or disclose your PHI will fall within one of the categories below.

Health Information Exchange We may participate in CRISP to share your medical records via secure, encrypted connections to enable your treating providers to access your health information when treating you. The information shared includes your medical history, previous diagnoses, test results (i.e., labs and imaging), current medications, allergies, and progress notes. This connection allows for real-time access without having to wait for records to be transferred between facilities. You may opt-out if you do not want your record shared with your treating providers through CRISP.

Treatment. We may use or disclose your PHI to provide medical treatment or services to you to manage and coordinate your medical care. For example, we may share your PHI with another health care provider who is treating you to be sure that provider has the PHI they need to diagnose and treat you.

Payment. We may use or disclose your PHI to obtain payment for your health care services. For example, we may provide your health plan with PHI that it needs before it can pay us for services we provided to you. Your health plan may also require us to share information with them to determine whether you are eligible for benefits.

Health Care Operations. We may use and disclose your PHI to manage, operate, and support the business activities of our practice. This includes, but is not limited to, licensing, quality assessment, business planning, and administrative activities. For example, we may combine outcome data from many patients to evaluate the need for new products, services or treatments. We may disclose information to health care professionals, students and other personnel for review and training purposes. We may also combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of specific residents. We may also use and disclose medical information to evaluate the performance of our staff and your satisfaction with our services.

Required by Law and Legal Proceedings. We will use or disclose your PHI when required to do so by an applicable law. For example, we may share your PHI when required to report suspected child abuse. We may use and disclose your PHI in response to court or administrative orders, subpoena, discovery request or other lawful process.

Abuse, Neglect, or Domestic Violence: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence. For example, if we believe that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees to the disclosure, or we are otherwise permitted or required by law to do so.

Law Enforcement. We may use and disclose PHI about you as required by federal, state and local laws. For example, we may disclose certain PHI if asked to do so by to a law enforcement official in circumstances such as:

- 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 in the facility; and
- in emergency circumstances to report a crime; the location of a crime or victims; or the identity, description or location of the person who committed the crime.

To Avert a Serious and Imminent Threat of Harm. Consistent with applicable law and our ethical standards, we may disclose PHI to law enforcement or other persons who can reasonably prevent or lessen the threat of harm in order to avoid a serious and imminent threat to the health or safety of an individual or the public. For example, the law may require such disclosure when an individual or group has been specifically identified as the target or potential victim of a threat.

Coroners, Medical Examiners, or Funeral Directors. We may disclose PHI to a coroner, medical examiner, or funeral director as necessary for them to carry out their duties, in accordance with applicable laws**.** For example, we may disclose PHI to a coroner for purposes of identifying a deceased person.

Organ and Tissue Donation Requests. We may share PHI about you with organ procurement organizations or other similar entities. If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye and tissue donation and transplantation.

Public Health. We may share PHI about you for certain public health activities, such as:

- Preventing disease
- For the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity
- Helping with product recalls
- Reporting adverse reactions to medications Reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition
- Releasing proof of immunization for students without an authorization if you have agreed to the disclosure on behalf of yourself or your dependent

.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law. For example, we may share your PHI with governmental units that oversee or monitor the health care system, government benefit and regulatory programs, and compliance with civil rights laws.

Research. We may use or share your PHI under certain circumstances. For example, we may disclose PHI to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal, after establishing protocols to ensure the privacy of your health information.

Workers' Compensation. We will disclose only the PHI necessary for Worker's Compensation in compliance with applicable Worker's Compensation laws. This PHI may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

Military, National Security, and other Specialized Government Functions and Activities. We may disclose PHI to military authorities under certain circumstances. For example, we may disclose your PHI, if you are in the Armed Forces, for activities deemed necessary by appropriate military command authorities for determination of benefit eligibility by the Department of Veterans Affairs or to foreign military authorities if you are a member of that foreign military service. We may disclose your PHI to authorized federal officials for conducting national security and intelligence activities or special investigations (including for the provision of protective services to the President of the United States, other authorized persons, or foreign heads of state) or to the Department of State to make medical suitability determinations.

Correctional Institutions. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose PHI about you. Such information will be disclosed to the correctional institution or law enforcement official when necessary for the institution to provide you with health care and to protect the health and safety of others.

De-Identified PHI. We may de-identify your health information as permitted by law. We may use or disclose to others the de-identified information for any purpose, without your further authorization or consent, including but not limited to research studies and health care/health operations improvement activities.

Business Associates. On some occasions we may share your PHI with a business associate, such as a consultant, cloud service provider, or other vendor. For example, while we are providing you with health care services, we may share your PHI with business associates to help us perform services related to billing, administrative support or data analysis. These business associates are required by HIPAA to protect your PHI. We may also share your PHI with a Business Associate who will remove information that identifies you so that the remaining information can be used or disclosed for purposes outside of this Notice.

Appointment Reminders. We may use your PHI to provide appointment reminders. We may contact you by mail, e-mail, or telephone. We may use the telephone number(s) you provide us to leave voice messages or send text messages.

Right to Object or Opt-Out of Certain Uses and Disclosures

Emergency circumstances. If there is an emergency situation and you cannot be given the opportunity to agree or object, we may use or disclose your PHI if it is consistent with any prior expressed wishes and the use or disclosure is determined to be in your best interests; provided that you must be informed and given an opportunity to object to further uses or disclosures for patient directory purposes as soon as you are able to do so.

- ***To families, friends or others involved in your care***: We may share with your family, your friends or others involved in your care information directly related to their involvement in your care or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or your death. We may share your PHI with these persons if you are present or available before we share your PHI with them and you do not object to our sharing your PHI with them, or we reasonably believe that you would not object to such sharing. If you are not present, and certain circumstances indicate to us that it would be in your best interests to do so, we will share information with a friend or family member or someone else identified by you, to the extent necessary. This could include sharing information with your family or friend so that they could pick up a prescription for you. We may tell your family or friends that you are in an ENT & Facial Plastics Surgery Specialists facility and your general condition.
- ***Disaster relief***: In the event of a disaster, we may release your PHI to a public or private relief agency, for purposes of notifying your family and friends of your location, condition or death. Whenever possible, we will provide you with an opportunity to agree or object.
- ***Fundraising.*** We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. For example, you may receive a letter from us asking for a donation to support enhanced patient care, treatment, education or research. If you have opted out, HIPAA prohibits us from making fundraising communication.

Uses and Disclosures that Require Authorization.

We are only permitted to use and/or disclose your PHI as listed below if we obtain your written authorization. In addition, other uses and disclosures that are not described in this Notice may only be made with your authorization. If you provide us with an authorization, you may revoke your authorization at any time by submitting a request in writing to our Privacy Officer. Revocation does not apply to PHI that has already been used or disclosed with your permission. You can obtain an authorization form from us upon request.

Psychotherapy Notes. Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death

Marketing Health-Related Services. We will not use your health information for marketing purposes unless we have your written authorization to do so. We are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in

exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Sale of PHI. We are not allowed to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). Any activity constituting a sale of your Protected Health Information will require your prior written authorization. **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by HIPAA, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Your Rights.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI about you that we use or disclose. Your request must be in writing to the Privacy Officer at the address listed below. If you have paid in full for a service and have requested that we not share PHI related to that service with a health plan, we must agree to the request. For any other request to limit how we use or disclose your PHI, we will consider your request, but are not required to agree to the restriction. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment.

Right to Request Alternative Method of Contact. You have the right to request that we communicate with you about confidential medical matters in a certain way or at a certain location. Your request must be in writing to the Privacy Officer at the address listed below. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request an alternative address for billing purposes.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your PHI of certain disclosures of your health information during the past six years. We will provide one accounting of disclosures a year at no charge, but will charge a reasonable, cost based fee if another accounting of disclosures is requested within 12 months. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Right to Access, Inspect, and Copy. You have the right to inspect and/or obtain a copy of PHI that may be used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes. Your request must be in writing to the Privacy Officer at the address listed below. If you request a copy of your PHI, we may charge you a reasonable fee to cover the costs associated with copying and mailing the information. If you request an electronic copy of your PHI that we maintain electronically, we will provide an electronic copy, and will do so in the electronic form or format you requested if the PHI is readily producible in that form or format. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your medical information, we will document our reasons in writing and explain any right to have the denial reviewed.

Right to Amend. If you feel that certain PHI 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 the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address listed below. You must provide a reason that supports your request. 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 medical information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose your PHI.

Paper or Electronic Copy. If you agreed to receive this Notice electronically, you have the right to obtain a paper copy of this Notice from us upon request.

Breach Notification Requirements. We are required by law to notify you following a breach of your unsecured PHI. We will give you written notice in the event we learn of any unauthorized use of your PHI that has not otherwise been properly secured as required by HIPAA. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Changes to this Notice. We reserve the right to make any changes in our Notice, and the new terms of our Notice are effective for all PHI maintained, created and/or received by us before the date changes were made. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available in our office and on our website.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with the Privacy Office, contact our Privacy Officer at the address or phone number listed below. We will not retaliate against you if you file a complaint.

Contact Information.

Linda Liepaskalna, Practice Administrator
ENT & Facial Plastic Surgery Specialists of Shady Grove
9420 Key West Ave, Suite 310
Rockville, MD 20850
ph. 301.315.5888
email: lliepaskalna@entshadygrove.com