Name: ______________________

Date of Birth: ______________________

FLORIDA PSYCHIATRIC ASSOCIATES

Date: ______________

PERSONAL INFORMATION – Please Print

Patient's Full Legal Name: Last: ______________________ First: ______________________ MI: ______

Patient's Address: Street: ______________________ City: ____________ State: ________ Zip: ________

Patient's Phone Number(s): Home: ____________ Work: ____________ ext. ________ Cell: ____________

E-mail: ______________________ Patient's Date of Birth: ____________ Patient's Sex: ☐ Male ☐ Female

Would you like to be enrolled in our Patient Portal so that you may access your records from home? ☐ Yes ☐ No

RESPONSIBLE PARTY'S INFORMATION – Please have a Photo ID (i.e. Driver License) available for copying

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Patient ☐ Guardian ☐ Lawyer ☐ Worker's Comp ☐ Other: ______

Responsible Party's SS#: ____________ Responsible Party's Name: Last: __________ First: __________ MI: ____

Responsible Party's Address: Street: ______________________ City: ____________ State: ________ Zip: ________

Responsible Party's Phone Number(s): Home: ____________ Work: ____________ ext. ______ Cell: ____________

Responsible Party's E-mail: ______________________ Responsible Party's Date of Birth: ____________

Responsible Party's Sex: ☐ Male ☐ Female

If Patient is a student: ☐ Full Time ☐ Part Time ☐ School: ______________________

Responsible Party's Employer: ______________________ Occupation: ____________ Date Started: ____________

INSURANCE INFORMATION – Please Provide card(s) for copying

1. Primary Insurance Company: ____

Name of Insured: Last: ______________________ First: ______________________ MI: ________

Insured's Address: Street: ______________________ City: ____________ State: ________ Zip: ________

Insured's Date of Birth: ______________________ Insured's Sex: ☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________________

Insured's Employer: ______________________ Effective Date: ____________

Policy Number: ______________________ Group #: ____________

2. Primary Insurance Company: ____

Name of Insured: Last: ______________________ First: ______________________ MI: ________

Insured's Address: Street: ______________________ City: ____________ State: ________ Zip: ________

Insured's Date of Birth: ______________________ Insured's Sex: ☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________________

Insured's Employer: ______________________ Effective Date: ____________

Policy Number: ______________________ Group #: ____________

Florida Psychiatric Associates

Name: ______________________________

Date of Birth: ________________________

FOR OFFICE USE ONLY

Entered By: ____ Date: ________________________________

Insurance Card(s) ☐ Yes ☐ No
Driver's License ☐ Yes ☐ No
Insurance Verified ☐ Yes ☐ No

Comments: ____

PERMISSION AND ACKNOWLEDGMENT

ACKNOWLEDGEMENT : ☐ I have recorded copy of the Office Notice of Privacy

TREATMENT AUTHORIZATION : The undersigned authorizes the professional staff of Florida Psychiatric Associates to administer behavioral health treatment to the named individual on the reverse side of this form. Furthermore (if applicable) the undersigned affirms that he/she is authorized and has legal standing consent to treatment on behalf of the patient.

Patient's Name: (Please Print) ______________________________________

Signature: ________________________________ **Date:** ________________

☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Guardian** ☐ **Other:** ______________

INFORMATION RELEASE : I agree to allow the release of my information to my Primary Care Physician for (Primary Care Physician) for the purpose of coordinating my care.

Signature: ________________________________ **Date:** ________________

ACKNOWLEDGE & INSURANCE PAYMENT AUTHORIZATION:

: I understand that I am responsible for payment for any service rendered regardless of whether the service is covered by an insurance company.

: I further understand that if my account is past due that it may be sent to a collection agency and the status of my account reported to the credit bureau.

: I authorize insurance benefits payable to those health care providers described above for services rendered by them.

Signature: ________________________________ **Date:** ________________

Name: ______________________

Date of Birth: ______________________

PERMISSION TO LEAVE MESSAGES: There may be insurances when your Doctor/Clinician may need to change or reschedule an appointment. To protect your confidentiality, your permission is needed to leave a message at home with anyone other than you.

Florida Psychiatric Associates has my permission to leave a message regarding my scheduled appointment with or by means of.

Please check your Choice(s):

- ☐ Spouse Name: ______________________
- ☐ Relative Name: ______________________
- ☐ Friend Name: ______________________
- ☐ Answering Number Number: ______________________
- ☐ Cell Phone Number: ______________________
- ☐ Text Message Number: ______________________

E-mail Address: ______________________

Signature: ______________________ **Date:** ______________

EMERGENCY CARE INFORMATION

Personal Physician: First Name: ______________ Last Name: ______________ Phone: ______________

Personal Physician's Address: Street: ______________ City: ______________ State: ________ Zip: ________

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?

☐ Yes ☐ No If yes, please complete/sign information release section on previous page.

Family and/or friends to be contacted in an emergency:

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

CURRENT CONCERNS

Please provide a brief description of the major concerns that let you to seek treatment/therapy at this time:

Name: ______________________

Date of Birth: ______________________

PREVIOUS PSYCHIATRIST/THERAPIST

Name of Clinician	Phone Number/Address	Treatment Dates

Describe the problems for whice you sought therapy in the past: ______________________

Your experience with previous therapy: ☐ Positive ☐ Neutral ☐ Limited ☐ Negative

Have you been hospitalized for psychiatric or substance abuse problem? ☐ Yes ☐ No If yes, please list:

Facility: __________ Dates: __________ Reason: __________

Facility: __________ Dates: __________ Reason: __________

Do you have any history of suicide attempts or history of assault? ☐ Yes ☐ No If yes, please describe:

MEDICATIONS

Pharmacy Name: ______________________

Please list all current drugs/medications, including over-the-counter:

Name of Medication:	Dose	Dates

Please list any previous psychiatric drugs/ medications:

Name of Medication:	Dose	Dates

Florida Psychiatric Associates

Name: ______________________

Date of Birth: ______________________

PHYSICAL HEALTH STATUS

Do you have any existing medical problems or physical symptoms of concern to you? If so, please describe.

____

____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

____ Date: ______________

____ Date: ______________

Allergies (Food/Environment/Drug) – Is your allergy mild, moderate, or severe?

____

____

Are you up to date on preventive care (physicals, vaccinations, etc)?

____

Current Height: ______________

Current Weight: ______________

Do you smoke? ☐ No ☐ Yes, (#) ________ per day

Do you drink alcohol? ☐ No ☐ Yes, (#drinks) ________ per week

Do you engage in any other substance/drug use? ☐ No ☐ Yes, if yes, please explain:

____

Do you exercise? ☐ Regularly ☐ Occasionally ☐ Rarely ☐ Never

How is your general food diet? ☐ Very healthy ☐ Questionably healthy ☐ Not very healthy ☐ Changes

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

FAMILY BACKGROUND

Have any family members had any moderate to server psychological or medical problems? If so, please describe:

____

____

Please describe your family relationship: ____

____

SOCIAL/OCCUPATIONAL/FAMILY FUNCTIONING

Your social network? ☐ No close friends ☐ One close friend ☐ Few friends ☐ Many friends

How often do you make contact with friends? ☐ Regularly ☐ Occasionally ☐ Infrequently ☐ Never

Florida Psychiatric Associates

Name: ____________________

Date of Birth: ____________________

Are you currently in a romantic relationship? ☐ No ☐ Yes. It is …….
☐ Generally positive ☐ Neutral ☐ Problematic

Are you able to talk to others about the concerns that bring you into therapy? ☐ No ☐ Yes

What is your living situation? ☐ Live alone ☐ Live with others, with whom? ____________________

How do you feel about (select one) work/school?
☐ Pleased ☐ Mostly satisfied ☐ Mixed ☐ Mostly dissatisfied ☐ Unhappy

Any major dissatisfaction with: ☐ Work ☐ School ☐ Other ____________________

If so, please explain ____________________

____

Please describe any hobbies or recreational activities: ____________________

ATTENTION PATIENTS

- When making your appointment, we are reserving a slot of time for your particular needs.
- We ask that **if you must change or cancel an appointment, please give us 48 hours' notice during the week (2 business days)**. This will allow us to schedule another patient during that time.
- **There is a $50 charge for not showing up for scheduled appointments.**
- **Repeated Cancellations or missed appointments will result in loss of future appointment privileges or discharge from the practice.**
- By initialing below you are indicating you have read and understood this policy

Initial ____________________

Florida Psychiatric Associates

Name: ______________________________

Date of Birth: ______________________

CREDIT CARD AUTHORIZATION

Please complete the following information.

I, ____, am authorizing Florida Psychiatric Associates, Inc. to charge my credit card for any services rendered as agreed to in the Treatment Consent Form. I also authorize Florida Psychiatric Associates to charge my card $50 in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 48 business hours in advance (In cases of emergency, this fee can only be waived by the provider).

Furthermore, for outstanding payments of services rendered. I authorize Florida Psychiatric Associates to charge my credit card for the full amount due. I will not dispute for sessions I have received, or that I have not cancelled less than 48 business hours in advance.

I further authorize Florida Psychiatric Associates to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type: ______________________________

Card #: ________________________________ Expiration Date: ______________________ CID: __________

Name as Printed on Card: ____

Relationship to patient: ____

Billing Address: ____

(Street, City, State & Zip)

Signature: ____ Date: ______________

(Client or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance. or participation in treatment (e.g. appointment or phone session) without payment rendered.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE
You May Refuse To Sign This Acknowledgment

I ____, have received a copy of Florida Psychiatric Associates Notice of Privacy Policies.

Signature: ______________________________ Date: ______________________

For Office Use Only

Florida Psychiatric Associates attempted to obtain written acknowledgment of receipt of his/ her Notice of Privacy practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented him/ her from obtaining the acknowledgment.
- ☐ Other (specify) ____

Name: ______________________

Date of Birth: ______________________

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use " ● " to indicate your answer)	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

FOR OFFICE CODING _______ + _______ + _______ + _______ = **Total Score:** __________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

THE MOOD DISORDER QUESTIONAIRE

Instructions: Please answer each question to the best of your ability:

1. Has that ever been a period of time when you were not your usual self and...	Yes	No
--- you tell so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
--- you were so irritable that you shouted at people or started fights or arguments?	◯	◯
--- you felt much more self-confident than usual?	◯	◯
--- you got much less sleep than usual and found you didn't really miss it?	◯	◯
--- you were much more talkative or spoke much faster than usual?	◯	◯
--- thoughts raced through your head or you couldn't slow your mind down?	◯	◯
--- you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
--- you had much mc we energy than usual?	◯	◯
--- you were much more active or did many more things than usual?	◯	◯
--- you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
--- you were much more interested in sex than usual?	◯	◯
--- you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
--- spending money got you or your family into trouble?	◯	◯

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these causes you like being unable to work; having family, money or legal troubles: getting into arguments or fights? *Please circle one response only*

◯ No Problem ◯ Minor Problem ◯ Moderate Problem ◯ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents. grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

Florida Psychiatric Associates

Patient's Name: _______________

THE BURNS ANXIETY INVENTORY

Place a check mark in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category I: Anxious Feeling	Not at all 0	Somewhat 1	Moderately 2	A Lot 3
1. Anxiety, nervousness, worry or fear	◯	◯	◯	◯
2. Feeling that things around you are strange or unreal	◯	◯	◯	◯
3. Feeling detached from all or part of your body	◯	◯	◯	◯
4. Sudden unexpected panic spells	◯	◯	◯	◯
5. Apprehension or a sense of impending doom	◯	◯	◯	◯
6. Feeling tense, stressed, "uptight" or on edge	◯	◯	◯	◯
Category II: Anxious Thoughts	**Not at all 0**	**Somewhat 1**	**Moderately 2**	**A Lot 3**
7. Difficulty concentrating	◯	◯	◯	◯
8. Racing thoughts	◯	◯	◯	◯
9. Frightening thoughts	◯	◯	◯	◯
10. Feeling that you are on the verge of losing control	◯	◯	◯	◯
11. Fears of cracking up or going crazy	◯	◯	◯	◯
12. Fears of fainting or passing out	◯	◯	◯	◯
13. Fears of physical illnesses or heart attacks or dying	◯	◯	◯	◯
14. Concerns about looking foolish or inadequate	◯	◯	◯	◯
15. Fears of being alone, isolated, or abandoned	◯	◯	◯	◯
16. Fears of criticism or disapproval	◯	◯	◯	◯
17 Pears that something terrible is about to happen	◯	◯	◯	◯
Category III: Physical Symptoms	**Not at all 0**	**Somewhat 1**	**Moderately 2**	**A Lot 3**
18. Skipping, racing or pounding of the heart (palpitations)	◯	◯	◯	◯
19. Pain, pressure, or tightness in chest	◯	◯	◯	◯
20. Tingling or numbness of toes and fingers	◯	◯	◯	◯
21. Butterflies or discomfort in the stomach	◯	◯	◯	◯

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Category III: Physical Symptoms	Not at all 0	Somewhat 1	Moderately 2	A Lot 3
22. Constipation or diarrhea	○	○	○	○
23. Restlessness or jumpiness	○	○	○	○
23. Restlessness or jumpiness	○	○	○	○
25. Sweating not brought on by heat	○	○	○	○
26. A lump in the throat	○	○	○	○
27. Trembling or shaking	○	○	○	○
28. Rubbery or "jelly" legs	○	○	○	○
29. Feeling dizzy, lightheaded or off balance	○	○	○	○
30. Choking or smothering sensations or difficulty breathing	○	○	○	○
31. Headaches or pains in the neck or back	○	○	○	○
32. Hot flashes or cold chills	○	○	○	○
33. Feeling tired, weak, or easily exhausted	○	○	○	○
Total score on items 1-33				

SCORING KEY FOR THE BURNS ANXIETY INVENTORY

TOTAL SCORE	DEGREE OF ANXIETY
○ 0-4	Minimal or no anxiety
○ 5-10	Borderline anxiety
○ 11-20	Mild anxiety
○ 21-30	Moderate anxiety
○ 31-50	Severe anxiety
○ 51-99	Extreme anxiety or panic

Please remember to save this PDF by going to File > Save As.

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call **1-877-696-6775.**

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1