Where Families Blossom

Dear Potential Clients and Patients:

We are delighted that you have chosen to come to SpringCreek for your fertility and reproductive endocrinology needs. We strive to offer compassionate, patient-centered reproductive care using cutting-edge, evidence based treatments.

In order for us to be more focused on your clinical needs during our initial visit, we are asking you to review and complete the following forms and agreements ahead of time. This letter contains:

- Client Intake Forms
- Patient Registration Forms
- Information Release Agreements
- Insurance Authorization & Financial Agreements
- Missed Appointment Policy
- Genetic Carrier Screening Information

These forms may be returned to us via appointments@SpringCreekFertility.com – our HIPAA compliant email, faxed, or mailed (please call for three day delivery time) prior to your appointment.

We look forward to working with you.

Sincerely,

Jeremy Groll, MD & the SpringCreek Fertility Team

SpringCreek Fertility
Dr. Jeremy Groll
7095 Clyo Road
Centerville, OH 45459
www.springcreekfertility.com
P. 937-458-5084

SpringCreek Fertility

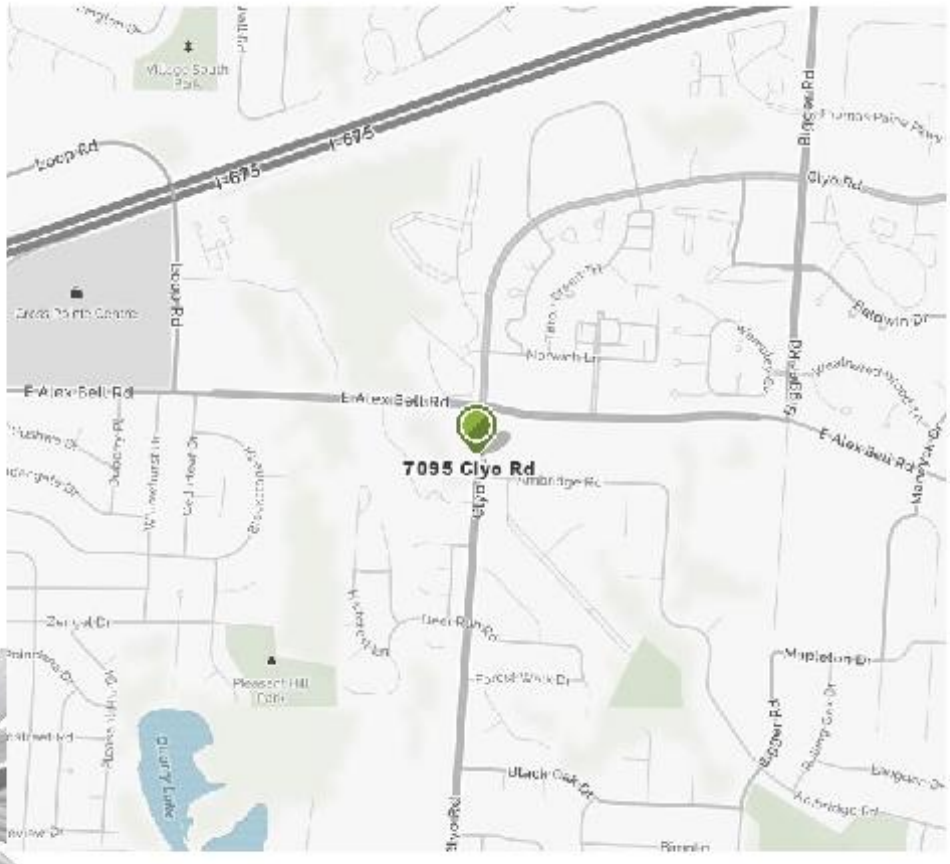
Dr. Jeremy Groll

7095 Clyo Road

Dayton, Ohio 45459-4816

937-458-5084

www.SpringCreekFertility.com



SpringCreek fertility

Where Families Blossom

CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Patient Phone: _____ **Social Security Number** _____

Dates of Treatment _____

I authorize _____
(Name of Referring Physicians Office)
Address: _____

Phone: _____ **Fax:** _____

to disclose the above named individual's information as described below:

Dates included: _____

o All records	o Labs Only
o HSG or Saline Sonogram	o Fertility Treatment Records including Flow sheets, Provider, and Nursing Notes
o Embryology Records	o Endocrine Test Results
o Male Testing (CSA, DFI, HBA & Endocrine Tests)	o Operative Reports

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

The information indicated above may be used by or disclosed to the following:

Jeremy Groll, MD ∴ SpringCreek Fertility
7095 Clyo Road ∴ Centerville OH 45459
Phone: (937) 458-5084 ∴ Fax: (937) 458-5089

This authorization will expire (less than 1 year from today's date) _____
I understand that authorizing the use or disclosure of the information indentified above is voluntary and I need not sign this form to ensure healthcare treatment.
Signature_____

Client Intake Form

Name: _____

Male History

Name: _____ DOB: _____

Is Insurance Information same as Patient? Y / N If not, please provide Insurance Card

Allergies? _____

Medications? _____

Medical or Genetic Problems in Family? _____

Medical Problems? _____

_____

Previous Children? N / Y How many? _____

Diet: _____ Exercise: _____

Tobacco? N / Y How much? _____ Alcohol? N / Y How much? _____

Surgeries? _____

_____

Previous Semen analysis? N / Y Results _____

_____

Male Patient Signature: _____ **Date:** _____

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Client Intake Form

Name: _____

Female History

What is the Reason for Your Appointment? _____

_____

_____

Allergies? _____

Medications? _____

Medical Problems ? _____

_____

Surgeries ? _____

Family Medical/Genetic History? _____

Menses occurs every _____ days. Lasts _____ days. Start of last period _____

Regular **Irregular** **Heavy** **Light** **Spotting** **Painful**

Date of Last Pap Smear _____ **Date of Last Annual Check-Up with Breast Exam** _____

Pelvic Pain? N / Y If Yes, describe: _____

How long have you tried for pregnancy? _____

Total Number of Pregnancies _____ **Term Deliveries** _____ **Preterm Deliveries** _____

Miscarriage _____ **Ectopic** _____ **Current Partner? Y / N**

Diet: _____ **Exercise:** _____

Tobacco? N / Y How much? _____ **Alcohol? N / Y How much?** _____

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Client Intake Form

Name: _____

Female History

Circle any that apply:

Wt. Gain	Wt. Loss	Hair Changes	Acne	Hot flash	Night Sweat
Snoring	Fatigue	Insomnia	Breast milk	Headaches	Vision changes
Palpitations	Constipation	Diarrhea	Urinary frequency	Bloody Urine	Pain during sex

Fertility Testing: **Where Performed:** _____

HSG: _____ Ultrasound: _____ MRI: _____ FSH: _____ LH: _____

AMH: _____ TSH: _____ Prolactin: _____ Testosterone: _____ DHEA-S: _____

Insulin: _____ Glucose: _____

Fertility Treatment:

Clomid or Femara? N / Y How many? _____

IUI? N / Y How many? _____

Gonadotropin? N / Y How many? _____

IVF/ICSI? N / Y Protocol & Dose _____ Estradiol level _____

Number of Eggs _____ Number of Embryos _____

Number of Frozen Embryos _____ FET? N / Y Pregnant? N / Y

Who is your OB/GYN? _____

Patient Signature: _____ **Date:** _____

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PATIENT REGISTRATION

SpringCreek Fertility

DEMOGRAPHIC INFORMATION

LAST NAME : _____ FIRST NAME : _____ MI : _____

DATE OF BIRTH : _____ (mm/dd/yyyy) SEX : _____ RACE : _____

SOCIAL SECURITY # : _____ ETHNICITY : _____

ADDRESS 1 : _____ ADDRESS 2 : _____

CITY : _____ STATE : _____ ZIP : _____

LANGUAGE : _____ LANGUAGE COUNTRY : _____

MARITAL STATUS : ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom **may we thank for referring you to our practice ?** _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

PARTNER NAME: _____ DOB _____

REFERRING PHYSICIAN / OB/GYN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME : _____ CONTACT LAST NAME : _____

CONTACT HOME PHONE : _____ CONTACT CELL PHONE : _____

RELATIONSHIP TO PATIENT : _____ CONTACT ADDRESS : _____

CITY : _____ STATE : _____ ZIP : _____

Signature of Insured/Guardian _____ **Date** _____

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PATIENT REGISTRATION

SpringCreek Fertility

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by SpringCreek Fertility in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction; however, if we do agree to your requested restriction(s), such restrictions are then binding to the Practice.

I agree and consent to	**Releasing information to me in the following manners:**
VIA MAIL	PLEASE INITIAL
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	_____
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	_____
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	_____
☐ OK TO FAX TO: _____	

I request my billing statement be sent by :

☐ Email - No Charge

☐ By Mail – Fee : We will send out one statement as a courtesy to you. If we are required to send out a second statement for a balance 14 days or older, we will add a statement fee of $10 for each additional statement on the outstanding balance.

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/Guardian : _____ **Date :** _____

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Authorized Methods of Communication

Patient Name: _____
(Please print) Date

Below, please list the name(s) and relationships of any person, other than yourself, that you authorize SpringCreek Fertility to release your medical information to.

I authorize SpringCreek Fertility to communicate information regarding my healthcare treatment and/or healthcare billing information to the following third parties (i.e., spouse, parent, partner, etc).

_____
PRINT Name Relationship

_____
PRINT Name Relationship

_____
PRINT Name Relationship

___ Please ✓ here if you **DO NOT** authorize release of any medical information to anyone other than yourself.

HOW would you like your appointment confirmed? Please ✓

___ Home ___ Work ___ Email ___ Cell

Do we have permission to leave a detailed message on your voicemail or with a family member? Please ✓

___ Yes ___ No

_____
Signature of Patient (or parent if under 18 or legal guardian) Date

INSURANCE INFORMATION

SpringCreek Fertility

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____ (what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE#: _____

EMPLOYMENT STATUS: Employed Unemployed F/T Student P/T Student Retired

OCCUPATION: _____ BUSINESS NAME: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian _____ **Date** _____

Financial Agreement and Insurance Authorization

I understand that all charges with Innovative Fertility of Ohio, LLC (InFO) dba SpringCreek Fertility (SCF) are my financial responsibility and that payment is expected at the time of service. However, if I am covered under an insurance plan that InFO dba SCF is a participating provider, my financial responsibility will be determined as outlined in the prover's contractual agreement.

Prior to your first appointment, it is your responsibility to **contact your insurance provider to determine your fertility benefits.**

Diagnosis codes often used at Innovative Fertility and SpringCreek Fertility include (but are not limited to):

N970, N97.1, N972, N979, N96, Z31.41

I agree to pay co-pays, estimated deductible amounts, and fees for non-covered services at the time of service. We will send billing statements out as elected in preferences on the Patient Registration Form. If no preference is selected, we will send via email. If the account becomes over 30 days past due, we may refer it to an outside collection agency. If the account is transferred to an outside agency for collection, a collection fee of 15% of the account balance will be added to the account prior to being transferred. Insurance claims not paid after 60 days become the responsibility of the patient. Returned checks will be subject to a $75.00 insufficient funds fee.

If we charge a credit card for payment and the charge is declined, we reserve the right to add a $75.00 collection fee for each payment that is declined.

Any missed appointments failing to give 24 hour cancellation notice will be subject to a $75.00 cancellation fee.

I understand my financial responsibility for services provided by InFO dba SCF. By signing below, I authorize Innovative Fertility of Ohio, LLC dba SpringCreek Fertility to release any medical information necessary to **facilitate insurance reimbursement.**

Name (please print)	Signature	Date

SpringCreek Fertility
Missed Appointment Policy

In order to provide care and access to all of our patients, SpringCreek requires twenty-four hours notice in the event that an appointment must be cancelled. If you cannot make your appointment, please call or email SpringCreek Fertility. You may leave a message either with the receptionist or on the appointment line. A SpringCreek associate is available between 7:00 am and 5:30 pm; the appointment line is available for messages 24 hours a day, 7 days a week.

For those appointments not cancelled 24 hours in advance, there will be a $75 charge. We may ask you to provide a credit card to put on hold for future appointments.

Please sign below stating 1) you have read our cancellation policy and 2) have been given a copy of the cancellation procedures for SpringCreek Fertility appointments. If you have questions or concerns, please talk to Lorie Groll, the Practice Administrator.

Thank you for your cooperation.

Name (please print)	Signature	Date

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Potential Initial Costs for Diagnostic Procedures

Depending upon your diagnosis, the initial consult and testing is typically covered by insurance. At the same time, this does not mean that these services will be paid for by your insurance. They may be applied to your deductible and as such, become your responsibility. In the days of high insurance deductibles, we want to provide you with some estimated contractual fees.

	Estimated Fee if Deductible Not Met
Initial Consult	$150 Deposit Or Credit Card on File
FSH, LH, HcG, Progesterone, Estradiol	We will bill your insurance and the allowable charges vary significantly depending upon insurance plan.
Other Serology	Sent to a third party lab who will bill your insurance. If you do not have insurance, you will need to call them for an estimate of costs.
Saline Sonogram	Credit Card on File or $750 Deposit
Follow Up Visit	Credit Card on File Or $75 Deposit

If your deductible has not been met, we will ask for either an estimated deposit or a credit card on file. We understand that some people are not comfortable with this arrangement so we do offer a cash deposit option. The choice is up to you. The actual amount your insurance allows may be more or less than the amount reflected here. The good news is that these services are often covered by insurance and if they are, these charges will go toward meeting your deductible.

We have a financial counselor that is willing to work with you to understand your benefits and the potential fees for any services we offer. Please give us a call with questions. We appreciate that you are including us in your fertility journey.

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GENETIC CARRIER SCREENING

What is genetic carrier screening?

Carrier screening, as prescribed by your healthcare provider, is a way to identify whether you are a "carrier "of various genetic disorders. Typically carriers are healthy individuals; but when two parents are carriers of the same genetic disorder they can have a child affected with the disorder. Knowing if you and your partner are carriers can help define your risk of having a child with that disorder.

What are the advantages of genetic carrier screening?

- For patients who are not carriers, expanded carrier screening provides reassurance that their child will be at a significantly reduced risk of developing any of the included genetic disorders.
- In most cases, if both parents are found to be carriers for *the same disorder* there is a significantly increased chance of having an affected child, and this knowledge can help guide future decisions.
- For couples who are found to be at increased risk for an affected pregnancy:
  - Your healthcare provider can help you understand the medical options available if you are planning on having a family.
  - If you are pregnant, you can pursue testing to determine if the pregnancy is affected, as well as work with your physician to learn about how to best care for treatable diseases.

Some of the conditions you may be screened for include:

Cystic Fibrosis (CF)

CF affects many different organs in the body, including the lungs, pancreas, and liver, lining them with an abnormally thick, sticky mucus. CF may cause chronic breathing problems and lung infections and CF patients have a lower life expectancy.

Spinal Muscular Atrophy (SMA)

SMA causes certain nerves in the brain and spinal cord to die, impairing the person's ability to move.

Fragile X Syndrome

Fragile X syndrome causes serious intellectual impairment and behavioral problems and is the most common form of inherited intellectual disability.

PLEASE MAKE A SELECTION AND SIGN BELOW:

❑ I have received information from my healthcare provider regarding genetic carrier screening and hereby **ACCEPT** this screening.

❑ I have received information from my healthcare provider regarding genetic carrier screening and hereby **DECLINE** to undergo this screening, despite being advised of the benefits of this option.

Patient name: _____DOB:_____

Patient Signature: _____Date:_____

This form is for informational purposes only and is not intended to provide legal advice or serve as a substitute for informed consent to be obtained by the ordering healthcare provider.

SpringCreek Fertility
7095 Clyo Road
Centervile, OH 45459

Health Insurance Portability and Accountability Act of 1996
Notice of Privacy Practices

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

SpringCreek Fertility is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the reception area. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the reception area. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card. If you choose to send photos of your family to our office, we may display them in areas that have public access.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing, collections, software support and quality assurance. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract. In addition, business associates are individually required to abide by the HIPAA rules.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Psychotherapy Notes: HIPAA-defined psychotherapy notes recorded by SpringCreek Fertility will only be used or disclosed with authorization by you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you regarding financial remuneration for services received at SpringCreek Fertility.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.
HITECH Reporting Requirements: Per the Health Information Technology for Economic and Clinical Health (HITECH) Act; a part of the American Reinvestment and Recovery Act (ARRA) of 2009;

SpringCreek Fertility is required to, and abides by the requirement to, report suspected breaches of unsecured PHI to both the potentially affected individuals and the Secretary of the Health and Human Services Department.

Your Health Information Rights

Although your health record is the physical property of SpringCreek Fertility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to SpringCreek Fertility in writing. The practice may charge $40 for additional requests for records after the first.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. SpringCreek Fertility will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be $10.00. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. You have the right to restrict certain disclosures of Protected Health information to a health plan where you pay out of pocket in full for the healthcare item or service. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

Notification of Breach: Individuals will receive notifications of any breaches of unsecured Protected Health Information.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (937) 458-5084 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

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

Privacy Officer: Lorie Groll x101
Telephone Number: 937-458-5084