SALEEBY AND WESSELS PROCTOLOGY PATIENT REGISTRATION FORM

Please print clearly

Name_____ SS#_____
First Middle Last Suffix

Birth Date _____ Age _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Address_____
Street City State Zip

Home Phone ( )_____Cell Phone ( ) _____ Work Phone ( ) _____

Occupation _____ Employer _____

Pharmacy Name _____
Street City State Zip

Spouses Name_____ SS#_____

Spouses Employer_____ Spouses Birth Date_____

Spouses Cell Phone ( ) _____ Spouses Work Phone ( ) _____

Email Address _____

Patient Portal Access Yes_____ No_____

NOTIFY IN CASE OF AN EMERGENCY

Name_____ Relationship_____

Home Address_____
Street City State Zip

Home Phone ( )_____Cell Phone ( ) _____ Work Phone ( ) _____

Do you have health insurance? ❑ Yes ❑ No

Primary Insurance Company_____

Policy Holder / Subscriber ID# _____Policy Holder Birth Date _____

Policy Holder Home Address _____
Street City State Zip

Secondary Insurance Company_____ Subscriber ID#_____

Primary Care Physician _____

How did you hear about our practice?_____

I certify that the information provided above is correct and complete to the best of my knowledge. I understand that all insurance information must be provided prior to services rendered. Furthermore, incomplete or incorrect information mayresult in claim denial or incomplete payment, which I would be financially responsible for.

_____ _____
Signature of Patient or Guardian Date

Name_____ **Age**_____ **DOB**_____

Referring MD_____ **Primary MD**_____

Reason for Visit: (chief complaint) _____

Medical Conditions: (ex. diabetes) _____

Prior Surgeries: (procedure and year) _____

Medications:(list drugs including aspirin, add sheet if needed)

1)_____ ____**mg** ____**times/day**
2)_____ ____**mg** ____**times/day**
3)_____ ____**mg** ____**times/day**
4)_____ ____**mg** ____**times/day**
5)_____ ____**mg** ____**times/day**
6)_____ ____**mg** ____**times/day**
7)_____ ____**mg** ____**times/day**

Medication Allergies: _____

Family History: What diseases run in your family? ☐Colon/Rectal Cancer ☐Polyps ☐Colitis/Crohn's Dz ☐other

Explain: _____

Social History: Marital status: ☐Single ☐Married Occupation:_____

☐Tobacco_____packs/day ☐Alcohol_____drinks or beers/day ☐Recreational drugs type(s)_____

Colon and Rectal Symptoms and History: (Check all that apply)

☐Anal or rectal pain
☐Anal protrusion
☐Push protrusion back inside
☐Anal swelling
☐Anal itching
☐Anal burning
☐Anal tags
☐Difficulty cleansing
☐Anal discharge
☐Blood on toilet paper
☐Blood in toilet
☐Blood in stool
☐Diarrhea
☐Change in stool size/frequency
☐Change in stool consistency
☐Constipation
☐Difficulty evacuating stool
☐Strain/push to evacuate stool
☐Use fingers to push out stool
☐Rectal fullness
☐Fecal Incontinence/soilage
☐Abdominal pain
☐Abdominal cramping
☐Abdominal bloating

Do you have a history of:

☐Fissure/tear
☐Abscess
☐Hemorrhoids
☐Fistula
☐Anal/Genital Warts
☐Anal Cancer
☐Colon/Rectal Cancer
☐Ulcerative Colitis
☐Crohn's Disease
☐Colon/Rectal Polyps
☐Diverticular Disease
☐Irritable Bowel Syndrome

How often do you move your bowels? _____ times/day _____times/week

The usual consistency of your stool is: ☐Hard ☐Formed ☐Mixed ☐Liquid ☐Alternates

Do you regularly use: ☐Laxatives (brand)_____ ☐Enemas ☐Fiber ☐Stool softeners

Do you use anal creams/suppositories/medicated or wet wipes? (list)_____

Have you previously had a: ☐Colonoscopy ☐Flexible Sigmoidoscopy ☐Barium Enema

Last Colonoscopy: (year) _____ **By Doctor:**_____ **Results:**_____

go to other side

Review of Systems: (check all that apply)

Constitutional:
- ☐weight loss
- ☐fever
- ☐chills
- ☐sweats
- ☐fatigue
- ☐poor appetite
- ☐weakness

Cardiovascular:
- ☐heart attack
- ☐chest pain/angina
- ☐stent placement
- ☐irregular beat
- ☐atrial fibrillation
- ☐valve disease
- ☐mitral prolapse
- ☐valve replacement
- ☐use antibiotics for dentist
- ☐rapid beat
- ☐pacemaker
- ☐high blood pressure
- ☐leg swelling
- ☐aneurysm
- ☐poor circulation
- ☐high cholesterol

Blood:
- ☐blood clots
- ☐on Coumadin/Warfarin
- ☐on Plavix
- ☐aspirin daily
- ☐sickle cell
- ☐leukemia/lymphoma
- ☐easily bruise/bleed
- ☐hemophilia
- ☐sickle cell disease

Pulmonary:
- ☐asthma
- ☐emphysema/COPD
- ☐shortness of breath
- ☐cough
- ☐embolism
- ☐lung mass/nodule
- ☐tuberculosis

Endocrine:
- ☐diabetes
- ☐hypothyroid/low
- ☐hyperthyroid/high
- ☐steroid use

Gastrointestinal:
- ☐ulcers
- ☐vomit blood
- ☐heartburn
- ☐reflux
- ☐nausea
- ☐vomiting
- ☐liver cirrhosis
- ☐jaundice
- ☐hepatitis
- ☐ascities
- ☐hernia

Genitourinary:
- ☐painful urination
- ☐blood in urine
- ☐air in urine
- ☐urinary infections
- ☐kidney stones
- ☐renal failure/dialysis
- ☐sexually-transmitted dz
- ☐genital warts
- ☐incontinence

Male:
- ☐testicle lump
- ☐erectile dysfunction
- ☐prostate enlargement
- ☐prostatitis
- ☐prostate cancer
  - ☐radiation therapy

Female:
- ☐breast mass/cancer
- ☐pain with intercourse
- ☐vaginal discharge
- ☐hysterectomy
- ☐cystocele
- ☐vaginal fistula
- ☐endometriosis
- ☐abnormal Pap smear
- ☐currently pregnant
  how far along? ____weeks
- ☐# children_____
- ☐vaginal delivery(s) #_____
- ☐episiotomy/tear #_____
- ☐forceps #_____
- ☐C-section(s) #_____
- ☐breast feeding currently
- ☐menopause

Psychiatric:
- ☐anxiety
- ☐depression
- ☐alcohol dependence
- ☐postpartum depression

Eyes:
- ☐wear glasses
- ☐cataracts
- ☐glaucoma
- ☐blindness

Ears/Nose/Throat:
- ☐nose bleeds
- ☐oral bleeds
- ☐hoarseness
- ☐deafness
- ☐ear ringing

Skin:
- ☐rash
- ☐psoriasis
- ☐itching
- ☐warts
- ☐skin cancer
- ☐shingles

Musk/Skeletal:
- ☐arthritis
- ☐joint pain
- ☐back pain
- ☐disc disease
- ☐gout

Neurological:
- ☐stroke
- ☐TIAs
- ☐nerve damage
- ☐seizures
- ☐dizziness
- ☐memory loss

Immune:
- ☐transplanted organ
- ☐fibromyalgias
- ☐lupus
- ☐rheumatoid arthritis
- ☐HIV/AIDS

other:

Patient's Signature_____ **Date**_____

History reviewed with patient **Doctor's Signature**_____ **Date**_____

SALEEBY AND WESSELS PROCTOLOGY FINANCIAL POLICY FORM

Patient Name_____ **Date of Birth**_____

This form is to outline our policy regarding payment for services. Please take the time to read it carefully. We will be happy to answer any questions you may have. Payment for service is due at the time service is provided in our office including, all copayments and deductibles. We accept **cash, checks, Visa** and **MasterCard.** You must bring your **insurance card** including any **Medicare** and **Medicaid** cards and your **driver's license** to your appointment.

For patients with Insurance: We bill most insurance carriers for you if proper and complete paperwork is provided to us **prior** to services being rendered. Incomplete information may result in claim denial which you would then be financially responsible for. If your plan requires a referral from your primary care physician, you are responsible for obtaining this prior to being seen. Failure to do so may result in claim denial which you will be financially responsible for. Prior to scheduled surgeries or colonoscopies, we will provide an estimate of our fees for the services, please note that this is neither a guarantee of payment by your insurance company nor an accurate reflection of your actual costs including copayments or deductibles as determined by your insurance carrier upon processing of your claims. Furthermore, prior authorization may be required by your carrier. If your plan has a high deductible, you will be asked to make a deposit prior to the procedure. In the event that your insurance carrier does not pay on your charges at the estimated rate or within a reasonable period of time upon request of this office, you will be responsible for the full balance due on the account. This includes all costs associated with collection efforts including but not limited to collection agencies, legal and attorney fees.

For patients with Medicare: We will bill Medicare for you. All copayments and deductibles are due at the time of service. In the case of services not typically covered by Medicare, you will be given the option to receive care at additional cost to you if Medicare denies your claim. This is outlined in the Medicare Advanced Beneficiary Notice which you must sign.

For patients with Medicaid: We will bill Medicaid for you. All coverage information must be complete and correct.

For self pay patients: Payment for service is due at the time of service. We can provide an estimate of our fees prior to services in the office. This is only an estimate and the actual amount may be higher or lower. Prior to scheduled surgeries or colonoscopies, we will provide an estimate of our fees for the services, please note that this is only an estimate and that your actual costs may be higher. Additionally, this estimate does not include the costs of the facility (hospital or ambulatory center) or the anesthesia, and you will be required to make payment arrangements for these services separately from this office. All surgeries and colonoscopies require a deposit upon scheduling.

I have read, understand and agree to the above financial policy for payment of fees. I agree to pay the balance owed on my account including costs associated with collection efforts. I understand that the patient is ultimately responsible for all professional fees.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Guarantor if different from above **and Relationship to Patient** **Date**

SALEEBY AND WESSELS PROCTOLOGY PAYMENT AUTHORIZATION FORM

Patient Name_____ **Date of Birth**_____

Please read this payment authorization form carefully. Sign the appropriate assignment of benefits which pertains to you. If you have **both** private insurance and Medicare you should sign **both.**

For Patients with Insurance

If you have health insurance other than Medicare or Medicaid please read and sign this assignment of insurance benefits:

I authorize this office to release any medical information related to my treatment including office visits, hospital care and outpatient procedures to any insurance company responsible for paying benefits pertaining to health services rendered to me. I further assign all medical and or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to this office for payment. This will remain in effect until revoked by me in writing. I understand that this assignment does not relieve me of my financial responsibility for all professional fees and charges incurred by me or anyone on my behalf and I accept all such responsibility. I am financially responsible for all charges whether or not paid by said insurance as well as costs associated with collection efforts including but not limited to collection agencies, legal and attorney fees. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Guarantor if different from above and Relationship to Patient **Date**

For Patients with Medicare or Medicaid

If you have Medicare or Medicaid please read and sign this assignment of insurance benefits:

I request payment of authorized Medicare and/or Medicaid benefits be made on my behalf to this office for any services provided. I assign the benefits payable for physician services to this office and authorize the office to submit a claim on to Medicare and/or Medicaid on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or appropriate North Carolina agencies any information needed to determine these benefits or the benefits payable to related services. This release applies to other insurers listed on approved claim forms as well. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and any non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Guarantor if different from above and Relationship to Patient **Date**

SALEEBY AND WESSELS PROCTOLOGY NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF INFORMATION

Patient Name_____ **Date of Birth**_____

This form describes how we may use and disclose your **Protected Health Information (PHI)** and how you can access this information. This notice is effective 4/13/2003. The HIPAA Privacy Notice has been provided in the office, as well as online at our website. Please review this form carefully and ask any questions if you do not understand something.

Your **PHI** is information about you that may identify you such as demographic information, past, present, and future physical and mental ailments or conditions, lab and other test results and medical and surgical services.

We may use and disclose your PHI for the purposes of **treatment** (plan, provide and coordinate your care including but not limited to other physicians, health care providers and health facilities), **payment** (including but not limited to health insurance companies, health facilities and billing services), **health care operations** (including but not limited to quality assessment, audits, statistics, training, licensing, transcription services, appointment reminders and contacting you), and other activities permitted or required by law.

We may disclose your PHI when it is deemed in your **best interest** by your physician including but not limited to family members or persons responsible for your care, to facilitate communication when necessary, and in an emergency situation.

We may disclose your PHI to any entity designated by you with your **written authorization**.

We may disclose your PHI **without** your consent or authorization when required by law, law enforcement authorities, a court, public health authorities, the Food and Drug Administration, when involving people exposed or at risk of contracting or spreading communicable or infectious diseases, and in cases of child or domestic abuse or neglect.

You have the following rights regarding your PHI:

- Request in writing, to inspect and copy your PHI.
- Request in writing, restriction on use and disclosure of your PHI. (but we are not required by law to agree to the restriction)
- Request in writing, to amend your PHI.
- Revoke this consent in writing at any time.(except to the extent that we have already taken action in reliance of this consent)
- Request a paper copy of this notice.
- You may complain to our privacy officer or the U.S. Dept. of Health and Human Services in writing if you believe your privacy rights have been violated. We will comply with Federal, State and Local laws on confidentiality of medical information.

Information that is disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

We reserve the right to change the privacy practices that are described above. You have the right to obtain a copy of the revised privacy practices.

I authorize Saleeby and Wessels Proctology to release my PHI to the named persons or organizations listed below: (check appropriate boxes and complete)

☐ **Spouse** _____
Print Name

☐ **Parent(s)** _____
Print Name(s)

☐ **Children** _____
Print Name(s)

☐ **Other** _____
Print Name(s) and Relationship to the Patient

I acknowledge that I have been provided with the Saleeby and Wessels Proctology Privacy Notification. I understand this form as well as my rights under the law as described above. I agree to consent to allow Saleeby and Wessels Proctology to use or disclose my PHI for the purposes described above.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Guardian or Representative **Relation to Patient** **Date**

SALEEBY AND WESSELS PROCTOLOGY MEDICARE ADVANCE BENEFICIARY NOTICE

Patient Name_____ **Medicare #**_____

Note: You need to make a choice about receiving these health care items or services.

We expect that Medicare **will not pay** for the item(s) or services(s) that are described below.
Medicare does not pay for all of your health care costs.
Medicare only pays for covered items and services when Medicare rules are met.
The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it.
There may be a good reason your doctor recommended it.
Right now, in your case, Medicare probably will not pay for:

Items or Services:

- Screening
- Screening Colonoscopy

Because:

- Medicare does not cover well visits.
- Medicare does not cover services that are not medically necessary for certain diagnoses.
- Screenings are only covered every 24 months.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should:

- Read this entire notice carefully
- Ask us to explain, if you don't understand why Medicare probably won't pay
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE YOUR CHOICE.

☐ **Option 1. YES I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items and services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____

Signature of Patient or Person acting on Patient's behalf **Date**

SWP OFFICE POLICIES AND PROCEDURES

PAYMENT

Copays, co-insurance and deductibles are due at the time of service. We accept cash, check, Visa, Mastercard, Discover and American Express. All returned checks will be assessed a $35.00 returned check fee in addition to the original charge.

INSURANCE CARDS

Insurance cards are required at every visit. If there are any changes to your insurance including, but not limited to, new insurance member identification number and / or group number please inform the office. If you have not provided our office with the correct insurance information, you will be responsible for any balance due.

SELF PAY PATIENTS

If you do not have insurance, your balance is due at the time of your office visit. Our office accepts cash, check, Visa, Mastercard, Discover and American Express.

MONTHLY BILLING STATEMENTS

Every month our office sends out a monthly billing statement to every patient. The balance due is the remainder owed after your insurance has paid. It is your responsibility to pay your monthly statement each month even if you and your insurance company are disputing coverage.

COLLECTIONS

If your account balance is unpaid and overdue after three monthly statements or more and you have not responded to any of our attempts to contact you, your account will be referred to a collection agency. Again, please note that we will only proceed to these measures if you do not respond to our attempts to communicate with you and set up a payment plan. Further correspondence regarding billing will then proceed through the collection agency.

PAPERWORK TO BE FILLED OUT BY THE DOCTOR

An appointment may be required to have forms completed. Please check with the staff to see if your form will require an office visit. If a scheduled appointment is required, your copay is due at the time of visit.

EXCHANGE OF MEDICAL INFORMATION

All requests by patients must be signed and in writing by letter, fax or a medical release of information form. Verbal requests are not acceptable. A request is not necessary if the information is shared with a physician that referred you to us or who we have referred you to.

COPYING FEES

We do charge a fee for the copying of medical records. The fee and length of time to copy the medical record is dictated by the size of the chart. Please give the office advance notice. Copying fee is due at time of pick up.

DIAGNOSIS CODES

Every effort is made to ensure correct coding and charges for visits based on medical documentation. Our office will not recode an office visit or outpatient procedure because your insurance plan does not cover certain visits/procedures or due to issues with copays, deductibles, and coinsurance. It is your responsibility to know what your insurance plan covers and what your responsibility for payment entails. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount that your insurance does not cover within 30 days.

RESULTS FROM TESTS

Our office will notify you with the results from testing as soon as they become available to us and are reviewed by your doctor. If another physician ordered the test and copies are sent to us, it is the responsibility of the ordering physician to contact you.

LATE FOR APPOINTMENTS

Our office values your time when scheduling visits and prioritizes seeing you on time.In order to try to ensure you are seen promptly during your visits, we ask that you arrive early to make sure all necessary paperwork and information is complete prior to your appointment time. Your appointment time is for actual doctor-patient timeand is not your arrival time. Generally, you should plan to arrive at least **20 minutes early** if you are **new**to us or have **not been seen in 12 months**, and at least **5 minutes early**if you have been seen in the last 12 months. This is to ensure all necessary information is updated and complete. Be advised,new patients or those not seen within the last 12 months will have several forms that need to be completed prior to being seen by the doctor. Please try to make every effort to notify our office if you will be arriving late. If you will be more than 10 minutes late or have forms that require time to complete prior to your visit, you willneed to reschedule your appointment.

NOT SHOWING FOR YOUR SCHEDULED APPOINTMENT

Our office tries diligently to schedule appointments in a timely fashion that is convenient for patients and meets the urgency of their particular condition. In order to do so in an efficient manner that minimizes the wait time for an appointment, our office must actively discourage patient no shows. We also actively discourage frequent appointment rescheduling. We understand that life is hectic, and many unforeseen issues can arise after scheduling an appointment. However, no shows as well as frequent rescheduling, hampers our ability to offer other patients a timelier appointment. Please notify us as early as possible if you know you will not be coming to your appointment, as this allows us to offer your spot to someone who is currently waiting otherwise. You can call the office between the hours of 8 am and 4 pm to cancel. You will also be reminded of your appointment by an automated telephone service 2-business days prior to your appointment day. This will come from number 919-787-2542 and will be to the phone number you provided as you preferred contact number. You will be given the opportunity to confirm or cancel your appointment via the automatic service at that time. In addition, we do require a **minimum of a 24-hour notice**be given when canceling or rescheduling an appointment.As a policy, any missed office appointment not cancelled at least 24 hours in advance will result in a **$50.00 fee** which is not covered by insurance. Any missed surgical or colonoscopy procedure similarly not cancelled at least 24-hours in advance will result in a **$100.00 fee** which is not covered by insurance.You will be required to satisfy late fees prior to rescheduling.

I acknowledge and understand the office policies and procedures.

Signature: _____ Date:_____

HIPAA Privacy Notice

SALEEBY AND WESSELS PROCTOLOGY
NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. WE ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE.

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. Understanding what is in your medical record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED:

For Treatment. We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you. For example, we may disclose information to people outside of our office when scheduling tests, arranging consultations with other physicians, phoning in prescriptions, etc.

For Payment. We may use and disclose protected health information to obtain reimbursement for the health care provided to you. We may also use this information to obtain prior authorization for proposed treatment or to determine whether your plan will cover the treatment. We will also share this information with our billing service as needed to facilitate their efforts towards reimbursement from you or your insurance company.

For Healthcare Operations. We may use and disclose protected health information to support functions of our practice related to treatment and payment such as case management and quality assurance. In addition, we may use your health information to evaluate staff performance, to help us decide what additional services we offer, and other management and administrative activities.

Appointment Reminders. We may contact you to remind you that you have an appointment or need a referral for an appointment.

Treatment Issues. We may call you with test results, to tell you about treatment options or alternatives, or to respond to your phone call and answer questions about your treatment.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits, services or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care.

Emergencies. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably possible after the delivery of your treatment.

Communication Barriers. We may use or disclose your protected health information if we have attempted to obtain consent from you but are unable to do so due to substantial communication barriers and we determine that your consent to receive treatment is clearly inferred from the circumstances.

Required by Law. We may use or disclose protected health information about you when required by federal, state or local law. The disclosure will be limited to the relevant requirements of the law.

Public Health Risks. We may use or disclose your protected health information for public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Communicable Diseases. We may disclose your protected health information, if required by law, to a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading the disease or condition.

Health Oversight Activities. We may disclose protected health information to federal or state agencies that oversee our activities.

Legal Proceedings. We may disclose protected health information in response to a court or administrative order or in response to a subpoena, discovery request or other lawful process.

Law Enforcement. We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process subject to all applicable legal requirements.

Workers Compensation. We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Military Activity and National Security. If you are or were a member of the armed forces or part of the National Security and Intelligence communities we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Coroners, Medical Examiners and Funeral Directors. We may disclose personal health information to a coroner or medical examiner if necessary to identify a deceased person or determine the cause of death. Protected health information may also be used and disclosed for cadaver organ, eye or tissue donation purposes.

Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals your identity.

Business Associates. There may be some services provided in our organization through contracts with Business Associated. Examples include our billing services, transcription services, and answering services, etc. When these services are contracted, we may disclose some of your protected health information to our Business Associate so that they can perform their job. To protect

your health information, however, we require the Business Associate to appropriately safeguard your information.

Inmates. We may use or disclose your protected health information if your are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOUR HEALTH INFORMATION RIGHTS:

You have the right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of your medical and billing records. A reasonable copying charge may apply. This request must be made in writing to our Practice Administrator.

You have the right to request a restriction of your protected health information. This means you may ask us to restrict or limit disclosure of any part of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or payment for your care. You must state the specific restriction requested and to whom you want the restriction to apply. However, this request is subject to our approval. If the physician believes it is in your best interest to permit use and disclosure of your information, it will not be restricted. If the physician does agree to the requested restriction, we may not use or disclose your protected health information unless it is needed to provide emergency treatment. You may request a restriction by speaking to your treating physician and/or the Practice Administrator.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must make this request in writing to our Practice Administrator and your request must specify how or where you wish to be contacted. We will not ask you the reason for your request.

You have the right to request a correction to your protected health information. This means you may request an amendment of your medical record if you believe the health information we have about you is incorrect or incomplete. You must make this request in writing. Forms are available for this purpose and can be obtained from the Practice Administrator. We may deny your request for an amendment if we feel it is inaccurate, or if the amendment you are requesting is part of the record that was not created by us. If we deny your request for amendment, you have the right to have your request and our denial added to your medical record.

You have the right to receive an accounting of disclosures of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operation, or for disclosures that occurred prior to April 14, 2003. You must make this request in writing to the Administrator and this request must include a time frame, which may not be longer than 6 years or may not include dates prior to April 14, 2003.

You have the right to obtain a paper copy of this notice from us. This may be obtained by contacting the Administrator or the office manager at your physician's clinical office location.

You have the right to register a complaint if you feel your privacy rights have been violated. If you believe your privacy rights have been violated, you may file a complaint with our office by

contacting the Administrator by phone (919) 787-2542 or by mail (Saleeby Proctology, 3814 Browning Place, Suite 100, Raleigh, NC 27609). You may also file a complaint with the Secretary of the Department of Health & Human Services. You will not be penalized for filing a complaint.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described above. You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on the use or disclosure indicated on the authorization.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date at the top. You are entitled to a copy of the notice currently in effect. This notice will be posted on our website at **www.saleebyproctology.com**