PAST MEDICAL, FAMILY & SOCIAL HISTORY (PFSH)

SPINE INSTITUTE OF LOUISIANA

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PERSONAL INFORMATION

(Please Print or Type)

Patient Name: _____ _____ _____
Last First M.I.

Registration Date: _____ / _____ / _____ Birthdate: _____ / _____ / _____ Age: _____

Social Security #: _____ - _____ - _____ Sex: _____

Address: _____ Apt. # _____
Street

_____ _____ _____
City State Zip

Telephone Numbers: (_____) _____ (_____) _____
Home Phone Cell Phone

Occupation: _____

Employer: _____
Name

_____ (_____) _____
Street Phone Number

_____ _____ _____
City State Zip

Dates of Injury/Onset: First Injury/Onset: _____ / _____ / _____
Second Injury: _____ / _____ / _____
Third Injury: _____ / _____ / _____
Fourth Injury: _____ / _____ / _____

Referring Source: _____
Name

_____ (_____) _____
Street Phone Number

_____ _____ _____
City State Zip

Referring Source is: ❑ Physician ❑ Chiropractor ❑ Other Healthcare Professional
❑ Another Patient ❑ Workers Comp ❑ Friend ❑ Yellow Pages

Family/Primary Care Physician: _____
Address _____
Phone Number _____ Date last seen by this provider _____

Other Physicians (pain medicine, cardiology, pulmonology, rheumatology, etc.): _____

Who completed this form? ❑ Patient ❑ Family Member ❑ Legal Guardian ❑ Other _____

Do you have a living will or advanced directive? ❑ Yes, up to date and on file at the Spine Institute of Louisiana
❑ Yes, but may need to be updated ❑ No, not interested ❑ No, but would like more information

Emergency Contact: *(A person not living at your residence)*
Name: _____ City: _____ State: _____
Day Phone: (_____) _____ Home: (_____) _____

Insured Information:
Name: _____ _____ _____
Last First M.I.
Birthdate: _____ / _____ / _____ Social Security Number: _____ - _____ - _____
Employer: _____ Work Phone: (_____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE :

_____ (_____) _____
Insurance Company Phone Number

_____ _____
Street Suite

_____ _____ _____
City State Zip

Group #: _____ Policy or ID #: _____

Subscriber's Name: _____

RELATIONSHIP: (**Circle One**) Self Spouse Mother Father

SECONDARY INSURANCE :

_____ (_____) _____
Insurance Company Phone Number

_____ _____
Street Suite

_____ _____ _____
City State Zip

Group #: _____ Policy or ID #: _____

Subscriber's Name: _____

RELATIONSHIP: (**Circle One**) Spouse Mother Father Self

WORKER'S COMPENSATION :

_____ (_____) _____
Insurance Company Phone Number

_____ _____
Street Suite

_____ _____ _____
City State Zip

File or Claim #: _____ Case Manager: _____

EMPLOYER AT THE TIME OF INJURY :

_____ (_____) _____
Company Phone Number

_____ _____
Street Suite

_____ _____ _____
City State Zip

ATTORNEY : *(Complete only if an attorney is representing you for this injury)*

_____ (_____) _____
Name Phone Number

_____ _____
Street Suite

_____ _____ _____
City State Zip

Do you want a copy of this report sent to your attorney? (**Circle One**) **YES** **NO**

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Address: _____

_____

Social Security Number: _____ **Date of Birth:** _____

Physician or Facility authorized to release health information:

_____

Name of releasing entity

Physician or Facility authorized to receive health information:

Attention: _____

Spine Institute of Louisiana
1500 Line Avenue, Suite 200
Shreveport, LA 71101
Fax: (318) 629-5556

Date(s) of service for health information covered by this authorization:

Start Date: _____ End Date: Current

Health information related to the patient to be released under this authorization:

☐ Complete Health Record
☐ Discharge Summary
☐ History & Physical Examination
☐ Consultation Reports
☐ Other (please specify): _____
☐ Progress Reports
☐ Laboratory Tests
☐ X-ray/MRI Reports

The following information will be released when included in the above unless indicated otherwise:

☐ Do not release any AIDS or HIV test results
☐ Do not release any records of psychiatric care
☐ Do not release any records of alcohol/substance abuse treatment
☐ Other: _____

Purpose of disclosure: Treatment of Spine or Neurologic condition

Date (or event) for expiration of authorization: _____

_____ _____

Patient's Signature Date

Spine Institute of Louisiana

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RESEARCH CONSENT FORM

I understand that as part of my health care, Spine Institute of Louisiana (SILA) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment. This important information may be used and disclosed for my treatment, so that my physician can get paid, and for various uses related to my physician's operations.

I understand that SILA'S *Notice of Privacy Practices* has a more complete description of how my health information may be used and disclosed to carry out these treatments, payments, or health care operations. I have the right to review the notice prior to signing this consent. I understand that SILA reserves the right to change those practices described in the Notice of Privacy Practices and, if it does so, the *Notice of Privacy Practices* will also change. A copy of any such change is available to me upon request.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that SILA is not required to agree to the restrictions I request but, if it does agree, it must comply with that agreement.

I have received a copy of SILA'S *Notice of Privacy Practices*, and I hereby consent to SILA using and disclosing my health information as described in the Notice of Privacy Practices, including any changes SILA may adopt in the future. I understand that I may revoke this consent in writing, except to the extent that SILA has already taken action in reliance on this consent.

Patient/Personal Representative Signature	Please Print Patient's Name
Relationship to Patient if Personal Rep.	Date Signed

PAST MEDICAL HISTORY

PRIOR ILLNESS	Yes	No		Yes	No		Yes	No	PAST SURGICAL HISTORY	Yes	No
Diabetes	❑	❑	Cancer	❑	❑	Heart Surgery	❑	❑	Lumbar Spine	❑	❑
Chest Pain/Angina	❑	❑	Osteoporosis	❑	❑	Blood Clots	❑	❑	Cervical Spine	❑	❑
High Blood Pressure	❑	❑	Asthma/COPD	❑	❑	Periph. Vasc. Disease	❑	❑	Coronary Stent	❑	❑
Heart Disease	❑	❑	Stroke/CVA/TIA	❑	❑	Tuberculosis	❑	❑	Coronary Bypass	❑	❑
Heart Attack	❑	❑	Seizures	❑	❑	Depression	❑	❑	Hip Surgery	❑	❑
High Cholesterol	❑	❑	HIV/AIDS	❑	❑	Cong. Heart Failure	❑	❑	Knee Surgery	❑	❑
Pacemaker	❑	❑	Hepatitis	❑	❑	Thyroid Disease	❑	❑	Shoulder Surgery	❑	❑
Headaches	❑	❑	Stomach Ulcer	❑	❑	Sleep Apnea	❑	❑	Craniotomy	❑	❑
Kidney Stones	❑	❑	Liver Disease	❑	❑	Aneurysm	❑	❑	Gall Bladder	❑	❑
Kidney Disease	❑	❑	Heart Palpatations	❑	❑	Spine Fracture	❑	❑	Appendix	❑	❑
			Arthritis	❑	❑	Severe Head Injury	❑	❑	Tonsillectomy	❑	❑
									Hysterectomy	❑	❑
									Carpal Tunnel	❑	❑

List ALL other major illnesses not mentioned above that have been treated in the past 5 years:

_____

_____

List ALL other previous surgeries (excluding the surgeries already detailed):

_____

_____

ROS	(-)	Please check all **CURRENT** positive problems
Constitutional	❑	Weight loss ❑ Fevers ❑ Chills ❑ Poor appetite ❑ Fatigue ❑ Weight gain ❑ Insomnia ❑ Night sweats ❑
Eyes	❑	Blurry vision ❑ Eye pain ❑ Eye discharge ❑ Eye redness ❑ Decrease in vision ❑ Dry eyes ❑ Double vision ❑
ENT	❑	Sore throat ❑ Hoarseness ❑ Ear pain ❑ Hearing loss ❑ Ear discharge ❑ Nose bleeds ❑ Tinnitus ❑ Sinus problems ❑
Cardiovascular	❑	Chest pain ❑ Palpitations ❑ Rapid heart rate ❑ Heart murmur ❑ Poor circulation ❑ Swelling in the legs or feet ❑
Respiratory	❑	Shortness of breath ❑ Chronic cough ❑ Coughing up blood ❑ History of Tuberculosis ❑ Excess sputum production ❑
Gastrointestinal	❑	Nausea ❑ Vomiting ❑ Diarrhea ❑ Constipation ❑ Blood in the stool ❑ Frequent hearburn ❑ Trouble swallowing ❑
Genitourinary	❑	Increased urinary frequency ❑ Blood in the urine ❑ Incontinence ❑ Painful urination ❑ Urinary retention ❑ Frequent UTIs ❑
Skin	❑	Rash ❑ Hives ❑ Hair loss ❑ Skin sores or ulcers ❑ Itching ❑ Skin thickening ❑ Nail changes ❑ Mole changes ❑
Musculoskeletal	❑	Joint pain ❑ Muscle aches ❑ Frequent leg cramps ❑ Muscle weakness ❑ Bone pain ❑ Joint swelling ❑ Back pain ❑
Psychiatric	❑	Anxiety ❑ Depression ❑ Alcohol or drug dependence ❑ Suicidal thoughts ❑ Panic attacks ❑ Use of anti-depressants ❑
Endocrine	❑	Goiter ❑ Heat intolerance ❑ Cold intolerance ❑ Increased thirst ❑ Change in skin pigment ❑ Excess sweating ❑
Neurological	❑	Seizures ❑ Tremors ❑ Migraines ❑ Numbness ❑ Dizziness/Vertigo ❑ Loss of balance ❑ Slurred speech ❑ Stroke ❑
Hem/Lymphatic	❑	Low blood count ❑ Easy bruising ❑ Swollen lymph nodes ❑ Transfusions ❑ Prolonged bleeding ❑ Blood clots ❑
Allergic/Immun	❑	Allergic reactions ❑ Hay fever ❑ Frequent infections ❑ Hepatitus ❑ HIV positive ❑ Positive tuberculin skin test (PPD) ❑

FAMILY HISTORY: *(Please list any known medical problems)*

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Has anyone in your family ever had any of the following conditions? **(Circle ALL that apply)**

❑ Arthritis ❑ Back pain ❑ Neck pain ❑ Cancer: Kind? _____

❑ Tuberculosis ❑ Heart trouble ❑ Migraine headaches

❑ Scoliosis ❑ Bleeding disorder ❑ Osteoporosis

SOCIAL HISTORY

Are you: (**Check One**) ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Number of children **and ages**, if any: _____

Are you: (**Check One**)
❑ Unemployed ❑ Employed ❑ Student ❑ Retired ❑ Disabled

How long have you been off work this year?
❑ No Time ❑ 1 to 2 months
❑ About 1 week ❑ About 2 to 6 months
❑ 2 to 4 weeks ❑ About 6 months to one year

Are you presently working? (**CHECK ONE**) ❑ **YES** ❑ **NO**
If you answered "**NO**", please complete the following:
1. What was the last date worked? _____ / _____ / _____
2. Is your job still available? ❑ **YES** ❑ **NO**
3. Was your reason for leaving work:
❑ Due to circumstances related to this problem
❑ Due to circumstances **NOT** related to this problem

Current source of income: (**CHECK ALL that apply**)
❑ Spouse ❑ Unemployment
❑ Employer ❑ Workers Compensation
❑ Social Security ❑ Family (other than spouse)
❑ Disability ❑ Other funds

Is your income sufficient to meet your needs? (**CHECK ONE**) ❑ **YES** ❑ **NO**

Are you a cigarette/cigar smoker? (**CHECK ONE**) ❑ **YES** ❑ **NO**
If you answered "**YES**", how much do you smoke per day?
❑ Less than 1/4 pack per day ❑ 1 pack per day
❑ 1/4 pack per day (5 cigarettes) ❑ 2 packs per day
❑ 1/2 pack per day (10 cigarettes) ❑ More than 2 packs per day
❑ 3/4 pack per day (15 cigarettes) ❑ Other: _____

Are you a previous cigarette/cigar smoker? (**CHECK ONE**) ❑ **YES** ❑ **NO**
If you answered "**YES**", please answer the following:
When did you quit?_____ How long did you smoke? _____

Do you drink alcoholic beverages? (**CHECK ONE**) ❑ **YES** ❑ **NO**
If you answered "**YES**", please circle your average consumption?
❑ Less than 4 drinks per month ❑ 1 to 2 drinks per day
❑ 1 to 3 drinks per week ❑ 3 to 5 drinks per day
❑ 3 to 6 drinks per week ❑ More than 5 drinks per day

Have you used any "Street Drugs" in the last year? (**CHECK ONE**) ❑ **YES** ❑ **NO**
If you answered "**YES**", what drug(s) and how often? _____

_____

MEDICATIONS:

Are you taking any medications (prescription or over-the-counter), vitamins, herbal supplements or contraceptives on a regular basis?

❑ Yes ❑ No If yes, list below:

Name of Medication	Strength of Each Dose	# of Doses at a Time	Frequency	Indication
Example: Lyrica	*75 mg*	*1 pill*	*2 times daily*	*Fibromyalgia*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				

IF YOU ARE TAKING MORE MEDICATIONS, PLEASE DISCUSS WITH YOUR PROVIDER.

Have you taken products containing aspirin in the last 14 days? ❑ Yes ❑ No
Have you taken any oral, inhaled, injected steroid or cortisone-type drugs in the past 30 days? ❑ Yes ❑ No
Have you ever been instructed or advised to take antibiotics prior to any dental work or medical procedures? ❑ Yes ❑ No
Have you ever been told NOT to take or to STOP taking a medication? ❑ Yes ❑ No
Have you taken any narcotic medications in the past 14 days? ❑ Yes ❑ No
Do you take insulin? ❑ Yes ❑ No
Do you take coumadin (warfarin)? ❑ Yes ❑ No

Check the box if you have ever had an allergy or sensitivity to each of the following items:

❑ Latex or rubber
❑ Specific foods
❑ Influenza (flu) vaccination
❑ Adhesive tape
❑ Betadine or skin disinfectant
❑ Iodine or X-ray contrast dye
❑ Other vaccines - Tetanus, Measles, Polio, etc.
❑ "-caine" anesthetics such as Xylocaine, Novacaine
❑ I have other allergies not listed
❑ No allergy to any of these items

List all medications, substances, foods, dusts, fumes, and animals to which you have allergies or unpleasant side effects.

List Drug or Item	Reaction	List Drug or Item	Reaction
Example: *Sulfa*	*Rash*		

Spine Institute of Louisiana

NOTICE OF PRIVACY PRACTICES

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

Effective Date: September 23, 2013

- IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER: Spine Institute of Louisiana Attention: Privacy Officer 1500 Line Avenue Suite 200 Telephone: 318-629-5555 Fax: 318-629-5556

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify and/or contact patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's

involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

HIV information, Alcohol and Substance Abuse information, Mental Health Information and Genetic Information

Louisiana law includes specific provisions regarding disclosure of HIV information, which generally cannot be disclosed pursuant a general authorization for other health information when such authorization includes a refusal to release HIV test results. However, HIV test results may be released to certain entities without consent under certain circumstances. These include, among others, health facilities/providers which are permitted access to medical records and authorized to obtain HIV test results, health facilities/providers when knowledge of HIV test results is necessary to provide appropriate care or treatment, when the disclosure is mandated by law or ordered by a court, and to an insurer or other entity responsible for paying for medical services to the extent necessary to secure payment for those services. Further, a physician may, but is not obligated to, notify a contact of an HIV infected person if the physician reasonably believes the disclosure is medically appropriate and there is a significant risk of infection to the contact. In such cases, the physician must counsel the infected patient regarding the need to notify the contact, and must reasonably believe that the patient will not inform the contact. The physician must also inform the patient of his or her intent to make such a disclosure and give the patient the opportunity to express a preference as to whether the disclosure should be made by the physician directly or to a public health officer for the purpose of disclosure.

Genetic Information - Louisiana law also includes provisions that address disclosure of genetic information. A general authorization for the release of medical records or medical information does not qualify as an authorization for disclosure of genetic information. Rather, a separate authorization is required.

Your Rights Regarding Your Protected Health Information - You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us; the request must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health 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. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.