



## Patient and Family History

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Child lives with: \_\_\_\_\_

Sibling Names: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address (if not the same): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address (if not the same): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

### Child's Health History

Former Doctor: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Child's weight at birth: \_\_\_\_\_

Does your child take vitamins, fluoride, iron, or any other supplements?  Y  N

List any medications your child is currently taking: \_\_\_\_\_

\_\_\_\_\_

**Please check all that apply to your child:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Ear Infections           | <input type="checkbox"/> Mumps, Measles    |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Eating Problems          | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Eczema/ Skin Problems    | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Emotional Problems       | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Eye Problems             | <input type="checkbox"/> Speech Problems   |
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Lung Problems     |
| <input type="checkbox"/> Congenital Heart Defect  | <input type="checkbox"/> Handicap/ Disabilities   | <input type="checkbox"/> Temper Problems   |
| <input type="checkbox"/> Convulsions/Epliepsy     | <input type="checkbox"/> Hearing Problems         | <input type="checkbox"/> Thumb Sucking     |
| <input type="checkbox"/> Croup                    | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Toilet Training   |
| <input type="checkbox"/> Dental Problems          | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Tonsillitis       |
| <input type="checkbox"/> Developmental Problems   | <input type="checkbox"/> Hepatitis, If so, Type__ | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Diarrhea or Constipation | <input type="checkbox"/> High Cholesterol         |  |
| <input type="checkbox"/> Discipline Problems      | <input type="checkbox"/> Kidney/Bladder Problems  |  |

Please describe any special medical conditions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Health Insurance**

Primary Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Patient ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

I authorize disclosure of information regarding my child's care. Please authorize who may be allowed to pick up prescriptions, contact office for an appointment, or accompany my child to an office visit if I am unavailable. I allow information to be released to the following:

1. \_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Relationship to Patient Phone Number

2. \_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Relationship to Patient Phone Number

3. \_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Relationship to Patient Phone Number

I hereby authorize payment directly to ANCIENT CITY PEDIATRICS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or by my dependents.

I authorize any provider or supplier of services in this practice to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Name of Responsible Party (Print)

\_\_\_\_\_  
Name of Responsible Party (Signature)

\_\_\_\_\_  
Date



1301 Plantation Island Dr S., Suite 404  
St. Augustine, FL 32080  
Phone: (904) 461-1560

## FINANCIAL POLICY

Thank you for choosing us as your child's health care provider. To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions, please discuss them with a member of our billing staff or office manager. We provide the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your child's care and treatment.

1. Upon arrival, please sign your child in at the front desk and present your current insurance card at **EVERY** visit. If you do not have your insurance card or insurance coverage cannot be verified via our online eligibility, you will be required to pay for all services in full at the time of service.
2. According to your insurance plan, Copays, Co-insurance, and Deductibles are to be collected at the time of service. We will collect copays, coinsurance, deductibles, and any prior balances at check in. Payment is required at the time of service regardless of who brings the child in for the appointment. We will not become involved in any separation or divorce disputes. Babysitters, grandparents, divorced parents, etc. must be prepared to make time of service payments even if they are not the account guarantor. There will be a **\$5.00** processing fee charged to your child's account if you are unable to pay these fees at the time of service.
3. If you have no insurance coverage, you will be required to pay for all services in full at the time of service. If you are not prepared to pay at this time, and the appointment is not of an urgent nature, you will be asked to reschedule the appointment.
4. **Please give 24-hour notice if you are unable to keep your appointment.** There is a **\$25.00 fee** for appointments that are not cancelled or if 24-hour notice is not given.
5. It is your responsibility to know and understand your insurance plan benefits. It is your responsibility to know if a written referral or authorization is required to see a specialist, if pre-authorizations are required prior to a procedure, if your insurance utilizes a specific lab, and what services are covered. Not all services provided by our office are covered by every plan. If your insurance carrier determines a service to be "non-covered", you will be responsible for the charge.

6. For your convenience, we accept cash, check and all major credit cards. A **\$25.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred. Payment for these fees must be paid by cash or with credit card prior to any future visits.
7. It is not policy of our office to file auto accident claims. You will be asked to pay for these services in full and will be provided with an itemized receipt to receive reimbursement from your auto insurance carrier.
8. Our office is by appointment only. **There will be an additional \$30.00 charge for any "walk-in" services.**
9. If medical records are requested by the parent for personal use, there will be a charge of \$1.00 per page.
10. We require a one week's notice for completion of any forms (camp, school, sports, etc.) that are presented to our office. If forms are not requested at the time of your child's annual well exam, there will be a **\$15.00** form fee charged to your account. Payment is due when the forms are picked up.
11. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you.
12. If you are having trouble paying your bill, have questions regarding any prior balance on your account, or are unable to pay on the day your child needs to be seen, please contact a member of our billing staff or the Office Manager prior to your appointment so that we may efficiently review the account, discuss your situation and answer any questions in a confidential manner.

Financial considerations should never prevent a child from receiving the care they need. We strive to remain understanding and flexible in individual circumstances and will do our best to help.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Signature: Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name: Parent or Guardian



1301 Plantation Island Drive, Suite 404  
St. Augustine, FL 32080  
Phone: (904) 461-1560 Fax: (904) 461-4304

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my authorization for Ancient City Pediatrics, LLC, to use and disclose protected health information about my child/children to carry out treatment, payment and healthcare operations. Ancient City Pediatrics, LLC's, Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this authorization. Ancient City Pediatrics, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With this authorization, Ancient City Pediatrics, LLC, or the appointed representatives may call/mail my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as, appointment reminders, patient statements, insurance items and any calls pertaining to my child's clinical care, including laboratory/radiology results among others.

With this authorization, I have the right to request that Ancient City Pediatrics, LLC, restrict how it uses or discloses my protected health information to carry out healthcare operations. However, Ancient City Pediatrics, LLC, is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am authorizing Ancient City Pediatrics, LLC, and/or its representative's use and disclosure of my protected health information to carry out healthcare operations. I may revoke this authorization in writing except to the extent that Ancient City Pediatrics, LLC, has already made disclosures in reliance upon my prior authorization. If I do not sign this form, I am authorizing that Ancient City Pediatrics, LLC, may decline to provide treatment.

I \_\_\_\_\_, have received and reviewed a copy of ANCIENT CITY PEDIATRICS, LLC's, Notice of Privacy Practices. By my signature, I acknowledge my understanding of the Notice of Privacy Practices.

\_\_\_\_\_  
Child's Name

\*\*OFFICE USE: we attempted to obtain written acknowledgment but could not due to:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

Initials: \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICE

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our Privacy Officer.

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### **A. How this medical practice may use or disclose your health information**

This medical practice collects health information about you and stores it in a chart. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. TREATMENT- We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose

medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. PAYMENT- We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before they pay us. We may also disclose information to other health care providers to assist in obtaining payment for services they have provided to you.
3. HEALTH CARE OPERATIONS- We may use and disclose medical information about you to operate the medical practice. For example, we may use and disclose information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", that perform administrative services for us. We have a written contract with each of these business associates that contain terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouse or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. APPOINTMENT REMINDERS- We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. SIGN IN SHEET- We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. NOTIFICATION AND COMMUNICATION WITH FAMILY- We may disclose your health information to notify or assist in notifying a family member, our personal representative or another person responsible for your care about your location, your general condition, or unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. MARKETING- Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. SALE OF HEALTH INFORMATION- We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. REQUIRED BY LAW- As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. PUBLIC HEALTH- We may, and are sometimes require by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgement, we believe the notification would place you at risk of a serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. HEALTH OVERSIGHT ACTIVITIES- We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. JUDICIAL AND ADMINISTRATIVE PROCEEDINGS- We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discover request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. LAW ENFORCEMENT- We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. CORONERS- We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of death.
15. ORGAN OR TISSUE DONATION- We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. PUBLIC SAFETY- We may, and are sometimes required by law, to disclose your health information to appropriate persons to prevent or lessen a serious and imminent threat to the health or safety f a particular person or the general public.
17. PROOF OF IMMUNIZATION- We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. SPECIALIZED GOVERNMENT FUNCIONS- We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. WORKERS COMPENSATION- We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers compensation insurer.

20. CHANGE OF OWNERSHIP- In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request the copies of your health information be transferred to another physician or medical group.
21. BREACH NOTIFICATION- In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. PSYCHOTHERAPY NOTES- We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. RESEARCH- We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. FUNDRAISING- We may use or disclose your demographic information to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health information status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

## **B. When this medical practice may not use or disclose your health information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your health information rights**

1. RIGHT TO REQUEST SPECIAL PRIVACY PROTECTIONS- You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

2. RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS- You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular address such as your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. RIGHT TO INSPECT AND COPY- You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible or will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our cost for

labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. RIGHT TO AMEND OR SUPPLEMENT- You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend it in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. RIGHT TO AN ACCOUNTING OF DISCLOSURES- You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of section A of this Notice of Privacy Practice or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. RIGHT TO A PAPER OR ELECTRONIC COPY OF THIS NOTICE- You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices.

#### **D. Changes to this Notice of privacy practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such an amendment is made, we are required by law to comply with the terms of this notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

#### **E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice hands your health information should be directed to our privacy officer.