**Summerhill Family Medicine**
**6680 Perimeter Drive**
**Suite 120**
**Dublin, Ohio 43016**
**Office: 614-792-5200**
**Fax: 614-792-5353**

# Patient Registration

## Patient Information (please print)

**Name**: _____ SSN: _____
Last First MI

**Address**: _____ City: _____ State: _____ Zip: _____

Marital Status _____ Cell/Home Phone: _____

Birth Date: _____ Circle Male/ Female **Email**: _____

Employer: _____ Occupation: _____

Employer Address: _____ Business Phone: _____

Emergency Contact: _____ Phone: _____

**Race**: American Indian/ Hispanic or Latino/Asian/ Black or African American/ Native Hawaiian/ White

**Ethnicity**: Hispanic or Latino/Not Hispanic or Latino/ Decline to Specify **Language**: _____

## Primary Insurance

Person Responsible for Account: _____
Last Name First Name MI

Relation to Patient: _____ ***Birth Date**: _____ ***SSN**: _____

Address (if different from patient): _____ Phone: _____

City: _____ State _____ Zip _____

Person Responsible Employed By: _____ Occupation: _____

Business Phone: _____

Insurance Company: _____

Grp #: _____ ID # _____

**Name of other dependents covered under the plan:** _____

## Additional Insurance

Subscriber Name: _____ Relation to Patient: _____

Address (if different from patient) _____ Phone: _____

City _____ State _____ Zip _____ Birth Date of Subscriber _____

Subscriber Employed By: _____ Business Phone: _____ SSN: _____

Insurance Company: _____

Group #: _____ ID# _____

**Name of other dependents covered under the plan:** _____

## Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to
Name of Insurance Company

Summerhill Family Medicine, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

***REQUIRED BY INSURANCE COMPANY**

**PEDIATRIC HEALTH HISTORY**

**SUMMERHILL FAMILY MEDICINE, INC.**

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.

Date _____ Social Security Number _____

Child's Name _____ ❑M ❑F Date of Birth _____

Mother's Name_____ Phone: Home(____)_____ Cell(____)_____

Father's Name _____ Phone: Home(____)_____ Cell(____)_____

Home Address _____

Child's School _____ Grade _____

Previous Physician _____ City/State _____ Phone (____)_____

**ALLERGIES**

| Substance | Reaction |
|---|---|
| | |
| | |
| | |

**MEDICATIONS**

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |

## MEDICAL HISTORY

Please check if child has ever had any of the following:

❑ Anemia
❑ Asthma
❑ Bronchitis/Bronchiolitis
❑ Bronchopulmonary Dysplasia
❑ Chicken Pox
❑ Hepatitis
❑ Immune Deficiency/HIV
❑ Measles (10 day)
❑ Measles, Rubella (3 day)
❑ Mumps
❑ Prematurity
❑ Rheumatic fever
❑ Pneumonia
❑ Sickle Cell Disease
❑ Whooping Cough
❑ Other _____

**GENERAL**
❑ Chills
❑ Depression
❑ Dizziness
❑ Fainting
❑ Forgetfulness
❑ Headache
❑ Loss of sleep
❑ Mood swings
❑ Nervousness
❑ Numbness
❑ Sweating
❑ Tiredness
❑ Weight loss/gain

**CARDIOVASCULAR**
❑ Breathing problems
❑ Chest pain
❑ Irregular heart beat

**EYES**
❑ Crossed or wandering
❑ Eye irritation
❑ Headaches
❑ Vision problems

**HEARING/SPEECH**
❑ Difficulty hearing
❑ Earache
❑ Ear infections
❑ Hoarseness
❑ Speech problems

**DENTAL**
❑ Bleeding gums
❑ Grinding teeth
❑ Sensitivity to hot/cold
❑ Thumb-sucking
❑ Last dental visit_____
❑ Brush, how often?____
❑ Floss, how often? _____

**GASTROINTESTINAL**
❑ Appetite poor
❑ Bloody or dark stools
❑ Constipation
❑ Diarrhea
❑ Excessive hunger
❑ Excessive thirst
❑ Nausea
❑ Rectal bleeding
❑ Stomachaches
❑ Vomiting
❑ Worms

**GENITO-URINARY**
❑ Bed-wetting
❑ Blood in urine
❑ Diaper rash, persistent
❑ Discharge from vagina or penis
❑ Frequent urination
❑ Painful urination
❑ Unusual urine odor

**MUSCLE/JOINT/BONE**
❑ Broken bones or sprains
❑ Coordination problems
❑ Posture problems
❑ Pain, weakness, swelling in:
❑ Arms ❑ Hips
❑ Back ❑ Legs
❑ Feet ❑ Neck
❑ Hands ❑ Shoulders

**NOSE/THROAT/CHEST**
❑ Difficulty breathing
❑ Difficulty swallowing
❑ Frequent colds
❑ Hoarseness
❑ Mouth-breathing
❑ Nosebleeds
❑ Persistent cough
❑ Sinus problems
❑ Sore throats
❑ Strep throat
❑ Tonsil infections
❑ Wheezing

**SKIN**
❑ Bruise easily
❑ Change in moles
❑ Hives
❑ Itching
❑ Rash
❑ Scars
❑ Sores that won't heal

## DIETARY ASSESSMENT

How often does your child eat the following:

| | 3 Times Daily | Daily | Weekly | Monthly |
|---|---|---|---|---|
| Breads, cereals, grains | ❑ | ❑ | ❑ | ❑ |
| Candy | ❑ | ❑ | ❑ | ❑ |
| Dairy products | ❑ | ❑ | ❑ | ❑ |
| Eggs | ❑ | ❑ | ❑ | ❑ |
| Fruits | ❑ | ❑ | ❑ | ❑ |
| Meats | ❑ | ❑ | ❑ | ❑ |
| Poultry, fish | ❑ | ❑ | ❑ | ❑ |
| Sodas | ❑ | ❑ | ❑ | ❑ |
| Vegetables, green | ❑ | ❑ | ❑ | ❑ |
| Vegetables, yellow | ❑ | ❑ | ❑ | ❑ |

What vitamin supplements does your child take?_____ How often?_____

Is there fluoride in your water? ❑ Yes ❑ No

## HOSPITALIZATIONS

| Reason | Date | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## INJURIES

| Serious injuries/illnesses | Date | Outcome |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child ever had a blood transfusion? ❑Yes ❑No

## IMMUNIZATIONS

Please check whether or not your child has been given the following immunizations. If yes, please fill in the date(s) given.

| Yes | No | Date | | Yes | No | Date | |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | _____ | Hepatitis B | ❑ | ❑ | _____ | Polio shots series of 3 |
| ❑ | ❑ | _____ | MMR Vaccine | ❑ | ❑ | _____ | Meningococcal |
| ❑ | ❑ | _____ | DPT series of 3 shots | ❑ | ❑ | _____ | Polio booster shots |
| ❑ | ❑ | _____ | Influenza Vaccine | ❑ | ❑ | _____ | DPT booster shots |
| ❑ | ❑ | _____ | Rotovirus | ❑ | ❑ | _____ | HPV Vaccine |
| ❑ | ❑ | _____ | Hib | ❑ | ❑ | _____ | Pneumococcal |
| ❑ | ❑ | _____ | Chicken Pox Vaccine | ❑ | ❑ | _____ | Other |

## FAMILY HISTORY

Please give the following information about your child's immediate family:

| | Age | General Health | | Age | General Health | |
|---|---|---|---|---|---|---|
| Father | _____ | _____ | Sibling | _____ | _____ | ❑M ❑F |
| Mother | _____ | _____ | Sibling | _____ | _____ | ❑M ❑F |
| | | | Sibling | _____ | _____ | ❑M ❑F |

Have any of your children died? ❑ Yes ❑ No

Please check conditions that any of the child's blood relatives (incl parents and siblings) have had and the relationship to the child:

| Condition | Relationship | Condition | Relationship |
|---|---|---|---|
| ❑ Alcoholism | _____ | ❑ HIV/AIDS | _____ |
| ❑ Allergies | _____ | ❑ Kidney Disease | _____ |
| ❑ Anemia | _____ | ❑ Lung Disease | _____ |
| ❑ Arthritis | _____ | ❑ Mental disease | _____ |
| ❑ Asthma/emphysema | _____ | ❑ Mental retardation | _____ |
| ❑ Birth defects | _____ | ❑ Muscle disorders | _____ |
| ❑ Bone/joint disorders | _____ | ❑ Rheumatic fever | _____ |
| ❑ Cancer | _____ | ❑ Seizures/convulsions | _____ |
| ❑ Diabetes | _____ | ❑ Sickle cell anemia | _____ |
| ❑ Epilepsy | _____ | ❑ Skin disease | _____ |
| ❑ Eye or ear disorders/Hearing loss | _____ | ❑ Stroke | _____ |
| ❑ Genetic defects | _____ | ❑ Thyroid disease | _____ |
| ❑ Heart disease | _____ | ❑ Tuberculosis | _____ |
| ❑ Hemophilia | _____ | ❑ Venereal disease | _____ |
| ❑ High blood pressure | _____ | ❑ Other | _____ |

## PRE-NATAL AND INFANT HEALTH HISTORY

Place of birth _____ Obstetrician _____ Mother's age at birth _____

During the pregnancy which conditions did you have? Please check all that apply:

- ❑ Alcohol use
- ❑ Anemia
- ❑ Diabetes
- ❑ Drug use, non-prescription drugs (Please list) _____
  _____
- ❑ Drug use, prescription drugs (Please list) _____
  _____
- ❑ Drug use, controlled drugs such as narcotics (Please list) ____
  _____
- ❑ Edema (Swelling)
- ❑ Exposure to chemical or radiation
- ❑ Fever
- ❑ German measles
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Protein in urine
- ❑ Tobacco use
- ❑ Urinary tract infection
- ❑ Venereal disease
- ❑ Other illnesses or infections_____

**DELIVERY** Please check all that apply:

❑ On time ❑ Premature ❑ Late ❑ Normal ❑ Induced ❑ Prolonged ❑ Breech ❑ C-Section

Please describe_____

**INFANT HEALTH**

Birthweight_____ Length _____
Discharge weight _____ Age when discharged_____

**INFANT HEALTH PROBLEMS** Please check and describe.

- ❑ Birth defects _____
- ❑ Breathing problems _____
- ❑ Infection _____
- ❑ Jaundice _____
- ❑ Transfusion _____
- ❑ Other _____

**FEEDING**

❑ Breast fed ❑ Formula fed

**DEVELOPMENTAL** Please note age at which your child

| | | |
|---|---|---|
| Lifted head | _____ | Weeks |
| Rolled over | _____ | Months |
| Cooed/Laughed | _____ | Months |
| Sat up | _____ | Months |
| Stood up | _____ | Months |
| Walked | _____ | Months |
| Finger fed | _____ | Months |
| Drank from cup | _____ | Months |
| Spoon fed | _____ | Months |
| First word | _____ | Months |
| Toilet trained | _____ | Months |
| Dressed self | _____ | Months |

## EDUCATION AND SOCIAL HISTORY

**Please explain any problems or concerns you have about your child in any of the following areas:**

Appearance/Weight/Height_____

Behavoir_____

Friends_____Get exercise?_____

Grades/learning ability_____

Sexuality_____

How many hours per day does your child watch television or play video games?_____
Do you suspect that your child is involved with: ❑ Drugs ❑ Alcohol ❑ Tobacco ❑ None

**Have you noticed any of the following warning signs of drug abuse?**

| | | | |
|---|---|---|---|
| Angry behavior | ❑ No ❑ Yes | Depression | ❑ No ❑ Yes |
| Changes in appearance | ❑ No ❑ Yes | Signs of drugs in the house | ❑ No ❑ Yes |
| Changes in attitude | ❑ No ❑ Yes | Skipping school | ❑ No ❑ Yes |
| Changes in friendships | ❑ No ❑ Yes | Withdrawal from friends or family | ❑ No ❑ Yes |

## CHILD SAFETY INVENTORY

| | | | | | |
|---|---|---|---|---|---|
| Adequate number of working smoke alarms? | ❑ Yes | ❑ No | Safety plugs in unused wall sockets? | ❑ Yes | ❑ No |
| Does child use car seat/seat belt? | ❑ Yes | ❑ No | Safety gate for stairs? | ❑ Yes | ❑ No |
| Medicines, cleaning supplies, etc out of reach? | ❑ Yes | ❑ No | Know dangers of paint, mice/rats in the home? | ❑ Yes | ❑ No |
| Know poison control phone number? | ❑ Yes | ❑ No | Does child know how to swim? | ❑ Yes | ❑ No |
| Water heater set below 120°? | ❑ Yes | ❑ No | Are guns in the home in locked storage? | ❑ Yes | ❑ No |
| Stranger awareness? | ❑ Yes | ❑ No | Does child use bicycle helmet? | ❑ Yes | ❑ No |

**PARENT CONCERNS:** Reason for visit today and any other concerns or questions you have about your child.

_____

_____

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Parent, Guardian or Personal Representative Relationship to patient

# Summerhill Family Medicine

**6680 Perimeter Dr.**
**Suite 120**
**Dublin, Ohio 43016**
**Office: 614-792-5200**
**Fax: 614-792-5353**

Wendy L. Summerhill, M.D.
Nicholas Ahner, PAC

Elizabeth Gross, PAC
Stephanie McDaniel, CNP

Date: _____

Patient Name: _____

Patient D.O.B.: _____

I allow Summerhill Family Medicine to share my medical information with the following people:

| | NAME | RELATIONSHIP |
|---|---|---|
| 1) | _____ | _____ |
| 2) | _____ | _____ |
| 3) | _____ | _____ |

_____
Signature of Patient

# Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Summerhill Family Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- 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

I understand that Summerhill Family Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Summerhill Family Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Summerhill Family Medicine change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____
Patient's Signature

_____
Date

---

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted. Explained purpose of Consent to patient by _____. Date consent was refused_____.

**Summerhill Family Medicine**
**6680 Perimeter Drive**
**Suite 120**
**Dublin, Ohio 43016**
**Office: 614-792-5200**
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Dear Patient:

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. We hope this will ensure we are able to maintain an excellent physician-patient relationship. Please ask if you have any questions about our fees, financial policy or your responsibility. We are mandated to collect your annual deductible and co-pays for each service. If our physicians and office staff do not comply with regulations we can be fined, sent to prison, no longer be allowed to participate in various insurance programs, and/or not allowed to practice medicine. Therefore, a twenty-five dollar fee will be assessed if your copay is not paid on the date of service.

In the past, doctors were able to make their own decisions regarding charges payments, courtesy discounts, etc. We are now scrutinized and monitored closely to ensure we comply with State and federal laws. As healthcare providers, we are trained to provide appropriate services for our patients. The managed care companies and government now outline which services we may provide, what we must document in your medical record, and what we must charge for specific services. Please be aware office and hospital visits charges are based on numerous items, such as: the number of problems/diseases, examination, acuity of your illness/disease, etc. Fees vary with the nature of your visit; and are based on services required by the doctor and staff to meet your health care needs.

- ♦All patients must complete our "Patient Information" form before seeing the doctor
- ♦We accept cash, checks, Visa, Mastercard.

**INSURANCE** We will do our best to help you receive maximum benefits. All charges are itemized for the convenience of your insurance company. We will be happy to bill them for your office visits, procedures and laboratory work If your insurance plan is not one with which we participate, we request payment-in-full at time-of-service, and will provide a copy of your encounter form so you can be reimbursed by your insurance company.

There has been a continual increase in private insurance companies requiring pre-certification for hospitalization or outpatient procedures. It is **your responsibility** to be aware of your insurance company's pre-certification requirements and alert us prior to hospitalization or outpatient procedures. Failure to do so could result in a partial or complete denial of benefits if your insurance company subsequently determines the services to be not payable.

We are happy to work with you to establish a mutually acceptable payment plan if you have difficulty with your account**. However, you are responsible for timely payment of your account.**

If you are fifteen minutes late to your appointment, we reserve the right to ask you to reschedule out of courtesy to our other patients.

We hope this helps clarify some of the policies, and we appreciate your understanding. Please feel free to speak with us if you have questions.

Thank you.

Wendy L. Summerhill, M.D.

**Summerhill Family Medicine**

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

# NOTICE OF PRIVACY POLICY

Effective April 1, 2003

The following is the privacy policy ("Privacy Policy") of Summerhill Family Medicine ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated hereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

## Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

## Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

*Examples of treatment activities include*: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

*Examples of payment activities include*: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

*Examples of health care operations include*:

(a) Development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs;
(d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death;
(f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity.

**Your Rights With Respect to Your Personal Health Information**

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or

death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access.

If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance.

The State of Ohio states that we can charge whatever the yearly rate is that they set each January:

1 With respect to data recorded on paper: ☐ ___ dollars and __ cents per page for the first 10 pages; ☐ __ cents per page for pages 11-50; ☐ __ cents per page for pages 51 and higher.
2 With respect to data recorded other than on paper, the actual cost of making the copy;
3 The actual cost of any related postage incurred by the health care provider or medical records company.

We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to **Summerhill Family Medicine 6680 Perimeter Drive, Dublin, Ohio, 43016.**

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately proceeding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to **Summerhill Family Medicine 6680 Perimeter Drive, Dublin, Ohio, 43016.**

## Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail to Summerhill Family Medicine 6680 Perimeter Drive, Dublin, Ohio, 43016. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

## Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will post any changes at our office and you may request a copy if you so desire.

## On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Summerhill Family Medicine 6680 Perimeter Drive, Dublin, Ohio, 43016.

# NEW POLICIES ENFORCED

- NO WALK IN PATIENT APPOINTMENTS AVAILIBLE
- PATIENT MUST CALL WITH REFILL REQUESTS AND ALLOW 24-48 HOURS TO BE FILLED.
- Any form that needs to be filled out by the provider must be presented at the time of the appointment if NOT a $10 form fee will be required.
- COPAY MUST BE PAID AT TIME OF SERVICE
- Any bill outstanding past 30 days must be paid in full before patient can be seen
- NEW PATIENTS and ALL physical appointment NO CALL NO SHOWS are charged $50 fee.
- Any missed appointment not canceled 24 hours prior will be charged a $30 fee. Special circumstances may apply at discretion of staff.
- Any appointment is considered “missed” if the patient does not arrive within 15 minutes of the appointment time without calling to notify the office of an anticipated delay. If the patient is more than 15 minutes late, it is up to the discretion of the physician to determine if the patient can be seen or needs to be rescheduled.
- A letter will follow the second missed appointment from the office notifying that patient of the discrepancies. The third missed appointment may result in a discharge of the patient at which the patient will receive certified mail that they have thirty days to find a new physician.