Living·at·Home Medical

居家樂醫療 Living·at·Home Medical, PC · 7105 3rd Avenue, #523, Brooklyn, NY 11209.1308
OFFICE 辦公室: 718.865.9333 · FAX 傳真: 888.972.7923 · EMAIL 電郵: mlee@lahmed.com · WEB 網站: www.lahmed.com

Dear Sir or Madam:

Thank you for making an appointment with Living-at-Home Medical! Attached please find these forms that are required before your first visit.

Patient Referral
Patient Consent & Acknowledgement
Health History
Authorization for Disclosure of Health Information
Chronic Care Management Consent
Permission to Photograph

Please read, fill them out, sign them and then fax them to **888.972.7923**. Alternately, you can scan the signed forms and upload them using the "Upload Documents" link here: **http://lahmed.com/homevisits/getting-started/**

We have also attached our Privacy Practices Notice for your information.

Looking forward to seeing you soon!

Sincerely,

Dr. Maria Bun-Ching Lee

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PATIENT REFERRAL FORM

Please fax to: 888.972.7923 (HIPAA Compliant)

Today's Date

Patient Information

Last Name | First Name | ☐ Male ☐ Female

Date of Birth | Social Security Number

Street Address | City | State | ZIP Code

Home Phone | Mobile Phone | Other Phone

Referrer Information

Referrer Last Name | First Name | Agency Name

Referrer Phone | Referrer Email

Family Caregiver to Contact for First Appointment

Last Name | First Name

Relationship | Phone

Insurance Information

if available, please fax copies of the insurance cards with this form

Medicare ☐☐☐☐☐☐☐☐☐☐ (9 numbers, 1 letter)

Medicaid ☐☐☐☐☐☐☐☐ (2 letters, 5 numbers, 1 letter)

Other Insurance: _____
Insurance Company Name | Member ID#

Comments

Office Use Only

☐ Insurance verified

Appointment Date ____/____/_____

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PATIENT CONSENT AND ACKNOWLEDGEMENT

Consent for Evaluation and Treatment

I hereby consent to and authorize Living-at-Home Medical, PC, its affiliates, physicians, employees (LAHM) to perform a physical examination and/or medical treatment deemed necessary. Treatment may include, without limitation, any required examination, medical, diagnostic or laboratory tests and medical procedures ordered by the physician(s) to be performed by the designated LAHM staff. I understand I may refuse treatment at any time.

I understand that LAHM would like me to be fully informed about how my protected health information will be used and disclosed.

Receipt of Notice about Privacy Practices

I acknowledge that I have reviewed or have been given an opportunity to review the LAHM Notice of Provider Privacy Practices. I may ask for a copy of the notice or can view it electronically at www.lahmed.com.

Consent to Use and Disclose Information

I acknowledge that I understand how my information will be used and disclosed, and give my voluntary consent to LAHM to use and disclose my protected health information for reasons as allowed or required as explained in the Notice.

Assignment of Benefits / Financial Responsibility Agreement

- If applicable, where I am treated on a private pay basis I understand I am responsible for payment of services in the amount agreed upon in advance.
- If applicable, where I am treated for a workers' compensation injury or illness LAHM will seek payment from the responsible payer, which
  is typically the employer or the employer's workers' compensation insurance carrier, in accordance with State or Federal workers' compensation laws.
- If applicable, for employer directed or required services (e.g. drug testing, physicals, medical surveillance) LAHM will seek payment from the employer. Individual patients may be responsible for payment only as allowed by State or Federal law.
- Where applicable, I understand that I am responsible to pay for deductibles, copayments and other charges in accordance with my benefit plan and determinations made by health insurance carriers, or charges determined by State or Federal workers' compensation programs, or your employer as allowed by law. Should my account be referred for collection, I understand that I may have to pay collection expenses incurred by LAHM, without limitation, court costs and attorney's fees as allowed by law.

Signature

By signing this form I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

Signature Of Patient or Legal Representative (If signed by other than patient, state relationship and authority to do so.) Date

Print – Name of Person Signing Form

Print – Name of Patient Date of Birth

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HEALTH HISTORY FORM

Patient:

Name of Patient Birth Date

Current/Past Medical Problems:

If you have recent test results or other documentation of your medical history, please make them available to me at the first visit.

Please list your current and past medical issues. For example: strokes, heart trouble, high blood pressure, thyroid problems, eye problems, etc.

Medical problem	Approximate date of onset or diagnosis

Past Surgeries

For example: gall bladder removal, appendectomy, hysterectomy, cataract surgery, prostate surgery, heart surgery, angioplasty, colonoscopy, etc.

Surgical procedure	Approximate date of surgery

Hospitalizations (within the last 2 years)

Reason for hospitalization	Date	Hospital

If you need to be hospitalized, which hospital(s) do you prefer?

Living·at·Home Medical

Name of Patient | Birth Date

HEALTH HISTORY FORM (continued)

Current Medications

Name of medicine	Strength	How often? #times/day	When? (AM / PM)	Why?	Prescribed by

Allergies or Reactions to Medications:

For example: rash, swelling, trouble breathing, etc

Medication	Reaction

Family History (Please list medical problems of close family members):

For example: dementia, cancer (include what type), heart disease, stroke, diabetes, hypertension, depression, etc.

Mother _____

Father _____

Siblings _____

Other _____

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Name of Patient _____ Birth Date

HEALTH HISTORY FORM (continued)

Review of Symptoms:

Please check and describe below any of the following symptoms you may be having.

General: ☐ Decreased appetite ☐ Fevers or sweats ☐ Chills ☐ Insomnia ☐ Sleeping more than usual

Current Weight: _____ pounds (OK to estimate)

Current Height: _____ inches (OK to estimate)

Weight Change: ☐ Loss ☐ Gain (_____ pounds over the past _____ months)

Eyes: ☐ Decreased vision ☐ Eye pain ☐ Tearing ☐ Dry eyes Date of last eye exam: _____

Ears, Nose, Throat & Mouth: ☐ Hearing loss ☐ Hearing aid ☐ Wax in ears ☐ Runny nose ☐ Sinus problems
☐ Dentures ☐ Swallowing problems ☐ Pain in mouth ☐ Dry mouth
Date of last dental exam: _____

Cardiovascular ☐ Chest pain ☐ Need to sleep sitting up to be comfortable ☐ Leg pain when walking

Respiratory: ☐ Shortness of breath ☐ Cough (Please describe: _____)

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal pain
☐ Heartburn ☐ Blood in stool ☐ Incontinent of stool (○ Sometimes ○ Always)
I typically move my bowels every _____ day(s)

Genitourinary: ☐ Frequent urination ☐ Urgent urination ☐ Burning urination
☐ Incontinent of urine (○ Sometimes ○ Always) Nighttime urination episodes: _____ times per night

Reproductive (for women): Number of pregnancies: _____ Number of live births: _____

Musculoskeletal: ☐ Joint pain (Location: _____) ☐ Joint swelling (Location: _____)
☐ Weakness in arms ☐ Weakness in legs ☐ One-sided weakness from stroke

Skin: ☐ Bed sore (Location: _____ Type of dressing: _____) ☐ Rash (Location: _____)
☐ Other skin problem (Please describe: _____)

Neurologic: ☐ Seizures ☐ Falling ☐ Memory loss ☐ Confusion ☐ Numbness
☐ Dizziness ☐ Tremor ☐ Paralysis

Psychiatric: ☐ Depression ☐ Anxiety ☐ Lack of motivation ☐ Suicidal thoughts ☐ Delusions
☐ Hallucinations ☐ "Sundowning" ☐ Irritability ☐ Threatening behavior

Endocrine: ☐ Vitamin D deficiency ☐ Thyroid disorder ☐ Heat or cold intolerance ☐ Hot flashes
☐ Diabetes (I check my blood glucose level _____ times/day. Morning glucose range: _____ Evening glucose range: _____)

Hemotology/Lymphatics: ☐ Easy bruising ☐ Leg or other swelling ☐ Anemia
☐ Other (Please describe: _____)

Allergy/Immunology: ☐ Environmental allergies ☐ Hay fever ☐ Allergies to foods

Any other problems not mentioned above? _____

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Name of Patient _____ Birth Date

HEALTH HISTORY FORM (continued)

Social History:

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ In a long term relationship ☐ Single, never married

Past Occupation(s): _____

Spouse's Occupation: _____

Education Level: ☐ Grade school ☐ High school ☐ GED ☐ College ☐ Advanced degree _____

Transportation: How often and for what purpose do you leave the house? _____

Tobacco:
☐ No, never smoked
☐ Previously smoked and quit in _____
☐ Yes, I am a current smoker. I smoke _____ cigarettes/packs (circle one) x day/week/month (circle one).

Alcohol: ☐ No ☐ Yes (Please describe: _____)

History of drug or alcohol problem? ☐ No ☐ Yes (Please describe: _____)

Immunization History:

Please list dates if known.

Influenza (Flu): ☐ No ☐ Yes ☐ Unsure Date _____ Given by _____

Pneumococcal (Pneumonia): ☐ No ☐ Yes ☐ Unsure Date _____ Given by _____

Tetanus: ☐ No ☐ Yes ☐ Unsure Date _____ Given by _____

Chicken Pox: ☐ No ☐ Yes ☐ Unsure Date _____ Given by _____

Zoster (shingles): ☐ No ☐ Yes ☐ Unsure Date _____ Given by _____

Daily Living Activities:

Check the appropriate box below.

Feeding: ☐ Need no assistance ☐ Need total assistance ☐ Need partial assistance (Describe: _____)

Bathing: ☐ Need no assistance ☐ Need total assistance ☐ Need partial assistance (Describe: _____)

Toileting: ☐ Need no assistance ☐ Need total assistance ☐ Need partial assistance (Describe: _____)

Dressing: ☐ Need no assistance ☐ Need total assistance ☐ Need partial assistance (Describe: _____)

Transferring: ☐ Need no assistance ☐ Need total assistance ☐ Need partial assistance (Describe: _____)

Walking: ☐ Need no assistance ☐ Need total assistance ☐ Need partial assistance (Describe: _____)

Living·at·Home Medical

Name of Patient _____ Birth Date

HEALTH HISTORY FORM (continued)

Durable Medical Equipment:

Please check off any of the medical equipment that you have in the home.

☐ Bedside commode	☐ Hospital bed	☐ Bathtub seat	☐ Mattress	☐ Heating pads
☐ Wheelchair	☐ Walker	☐ Crutches	☐ Canes	☐ Bedside rails
☐ Tube feeding pump	☐ Suction machine	☐ Nebulizer	☐ Ventilator	☐ Oxygen

☐ Others (Please list: _____)

Advance Directives:

Do you have the documents listed below? If you have any of these documents, please have a copy made to be placed in your medical files.

Health Care Proxy:	☐ No	☐ Yes	☐ Unsure
MOLST Form:	☐ No	☐ Yes	☐ Unsure
Living Will:	☐ No	☐ Yes	☐ Unsure
DNR (Do Not Resuscitate) Form:	☐ No	☐ Yes	☐ Unsure

Concerns:

What are the main concerns you would like to have addressed at the first visit?

_____

_____

_____

_____

Signature:

_____

Signature Of Patient or Legal Representative *(If signed by other than patient, state relationship and authority to do so.)* Date

_____

Print Name

_____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

Name of Patient / Previous Names | Birth Date | Medical Record Number

Street Address | City | State | ZIP Code

Authorizes:

Name of Health Care Provider / Plan / Other

Street Address | City | State | ZIP Code

Release Of Protected Health Information To:

Living-At-Home Medical, PC 7105 3rd Avenue, 523, Brooklyn, NY 11209
FAX: 888.972.7923 (HIPAA Compliant)

Information to be Released:

- ☐ Medical History
- ☐ Treatment or Tests
- ☐ Laboratory Reports
- ☐ Progress Notes
- ☐ Hospital Records Including Reports
- ☐ Medication List
- ☐ Surgical Reports
- ☐ X-ray Reports
- ☐ Consultations
- ☐ Immunizations
- ☐ Allergy Records
- ☐ Entire Record
- ☐ Other (Specify) _____

Purpose for Need of Disclosure (Check applicable categories):

- ☐ Further Medical Care
- ☐ Changing Physicians
- ☐ Legal Investigation or Action
- ☐ Other (Specify) _____
- ☐ Personal
- ☐ Insurance Eligiblity/Benefits

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the office at 718.865.9333. **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization.** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the office at 718.865.9333. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date. This authorization is good until the following date(s) _____ or for one year from the date signed.

Signature:

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Of Patient or Legal Representative *(If signed by other than patient, state relationship and authority to do so.)* Date

Print Name

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CHRONIC CARE MANAGEMENT CONSENT FORM

Print Patient Name

You agree and consent to the following:

- Your physician or nurse practitioner will bill Medicare for 20 or more minutes of Chronic Care Management (non face-to-face activities) once a month. The fee for this service allowed by Medicare is $40-$50, and your portion (or that of secondary insurance) will be 20% of the Medicare fee.
- Our account may reflect this monthly charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for this service to you per month. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let us know if you have entered into a similar agreement with another provider in another practice.
- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.

You will have a right to:

- Obtain a Comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
- Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the Chronic Care Management Stop Form.

You are aware that if you do not agree to participate in the Chronic Care Management program at Living-At-Home Medical we would no longer be able to:

- return phone calls to discuss concerns, including urgent issues,
- give medication refills requested via phone,
- order tests (lab tests, xrays, EKG's, ultrasounds) outside of the medical visit,
- make referrals to home care services, and specialists outside of the medical visit,
- communicate with specialists, or with doctors in the hospital if you are hospitalized.

Signature:

I agree to participate in the Chronic Care Management program. ☐ **Yes** ☐ **No**

Signature Of Patient or Legal Representative *(If signed by other than patient, state relationship and authority to do so.)* Date

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PERMISSION TO PHOTOGRAPH

I, _____ , give consent to Living-At-Home Medical, PC (LAHMed)
Print Patient Name
to take a digital photo of me.

I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I am seen for medical care.
- The photo will be stored securely to protect my privacy.
- The photo will NOT be used outside of LAHMed, unless I (or my legal representative) give my permission in writing.
- LAHMed will own the photo. I can look at the photo, or get copies, if I (or my legal representatives) sign a release form.

Signature:

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Of Patient or Legal Representative *(If signed by other than patient, state relationship and authority to do so.)* Date

☐ I Decline _____
Date

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NOTICE OF PROVIDER PRIVACY PRACTICES

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

Effective Date: December 11, 2013

Living-At-Home Medical, PC must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. We must follow the privacy practices described in this notice. If you have any questions about this notice, please contact Maria Lee, MD, the Privacy Officer.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

How We May Use And Disclose Health Information

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer, Maria Lee, MD.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations

As Required by Law. We will disclose Health Information 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 Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

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

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities 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 Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if 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 practically can do so.

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:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. 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.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Maria Lee, MD. 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 of 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 an Electronic Copy of Electronic Medical Records. 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.

Living·at·Home Medical

NOTICE OF PROVIDER PRIVACY PRACTICES (continued)

Right to Amend. If you feel that 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 our office. To request an amendment, you must make your request, in writing, to Maria Lee, MD.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Maria Lee, MD.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Maria Lee, MD. 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 agree, we will comply with your request unless the information is needed to provide you with 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 about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Maria Lee, MD. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.lahmed.com. To obtain a paper copy of this notice, you must make your request to Maria Lee, MD.

Changes To This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice on our web site, www.lahmed.com. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Maria Lee, MD. All complaints must be made in writing. **You will not be penalized for filing a complaint.**