# DIGESTIVE DISEASE ASSOCIATES

## INSTRUCTIONS FOR DIRECT ACCESS SCREENING COLONOSCOPY

Please fax, mail or deliver all documents to the appropriate office location below:

Catonsville:
700 Geipe Road, Suite 230
Catonsville, MD 21228
Phone: 410-715-4655
Fax: 410-247-4227

Columbia:
10710 Charter Drive, Suite 110
Columbia, MD 21044
Phone: 410-715-4655
Fax: 410-730-0942

Thank you for contacting our office for a Direct Access Screening Colonoscopy. This process will potentially allow you to have your procedure without first being seen by one of our gastroenterologists. Please be aware this program is for individuals without any gastrointestinal symptoms with a medical history that meets the guidelines for the program.

This document contains your Direct Access Screening Colonoscopy forms. Please complete **ALL** forms, include the additional documents requested below and return them by fax (numbers above), mail or drop off to the appropriate office.

1. A copy of your insurance card(s), front and back.
2. A copy of your referral from your insurance carrier, if required by your insurancepolicy.
3. A copy of your most recent history and physical or office visit notes from your primary care physician (PCP) and/or a copy of the office notes from your referring physician. Your PCP can also fax the information to our office.

Upon receipt of your documents, a physician will evaluate your medical information to ensure you are a candidate for a Direct Access Screening Colonoscopy. Our staff will contact you within 10-14 days to schedule your procedure, or if you do not qualify, schedule your office visit. If you do not receive a call in 10-14 days, please call our office.

Confirmation of your scheduled procedure (or appointment) as well as instructions for your procedure will be mailed to you. Dietary and bowel preparation instructions will be included.

Thank you for selecting Digestive Disease Associates for your medical care.
If you have any questions concerning your procedure or the process, please contact us!

# DIGESTIVE DISEASE ASSOCIATES

**Location Preference**
- o Catonsville
- o Columbia

Patient Name:_____ DOB: _____
Referring Physician:_____ GI Physician Preference: _____

## Direct Access Screening Checklist

Please complete the following questions to assess the patient's eligibility for a Direct Access Screening Colonoscopy. If you answer yes to any of these questions, you may need an office visit before your procedure is scheduled.

1. **Yes No** Is the patient over 65?

2. **Yes No** Does the patient weigh more than 315 lbs and have a BMI above 45?
   Patient's Height_____ Patient's Weight_____ BMI _____

3. **Yes No** Has the patient had a change in his/her medical history in the last year?
   ***If yes, please provide date (month and year).***
   heart attack_____irregular heartbeat _____
   coronary artery stent replacement_____stroke_____seizure _____

4. **Yes No** Has the patient ever seen a cardiologist (*heart doctor*)?
   If yes, what is the doctor's name? _____

*5.* **Yes No** Does the patient have any current gastrointestinal symptoms that need to be addressed with the physician prior to the procedure? (*this includes heartburn, abdominal pain, bleeding, weight loss, diarrhea, constipation or anemia)*

***6.*** **Yes No** Is the patient currently on dialysis, have a defibrillator, pacemaker, artificial heart valve, breathing issue requiring home oxygen, or being monitored by a respiratory doctor.
***(Please circle all that apply.)***

7. **Yes No** Is the patient on any blood thinners other than aspirin?

8. **Yes No** Will the patient have any contraindications (problems) stopping the following medications 5-7 days prior to your procedure?
   ***(Aspirin, Ibuprofen, Motrin, Advil, or any other non-steroidal medication***

9. **Yes No** Is the patient a diabetic
   **Yes No** If yes, does the patient have an insulin pump?

# DIGESTIVE DISEASE ASSOCIATES

PATIENT DEMOGRAPHICS AND INSURANCE FORM

Treating doctor (please check) ○ Abernathy ○ Alex ○ Andorsky ○ Banegura ○ Crosse ○ Harris ○ Joy ○ P. Kim ○ Narayen ○ Ravendhran ○ Salas ○ Sardana ○ Solomon ○ van den Broek

***Patient Information***

○ Dr. ○ Mrs. ○ Ms. ○ Miss ○ Mr. Today's Date: _____

First Name: _____ Middle : _____ Last : _____

Street Address: _____ City, State, Zip: _____

Home Phone#: _____ Work Phone#: _____ Cell Phone#: _____

When we contact you to remind you of your appointment, should we contact your?: ○ Home # ○ Cell Phone #

E-mail Address: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Race: ○ American Indian ○ Asian ○ Black or African American ○ White ○ Declined ○ Other _____

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Declined ○ Other _____

Language: ○ English ○ Spanish ○ Indian ○ Chinese ○ Korean ○ Other _____

Birth Date: _____ Sex: ○ Male ○ Female Social Security #: _____

Employer: _____

In case of emergency, notify: _____ Daytime Phone #: _____

Financially Responsible Person: ○ Self ○ Parent Name, if different than patient: _____

Address, if different than patient: _____

Phone#, if different than patient: _____

***Primary Insurance Section:***

Company Name: _____ Phone #: _____

Claims Address: _____

Policy Number: _____ Group #: _____

Name of Policy Holder: _____ Employer: _____ Policy Holder's Birth Date: _____

Sex: ○ Male ○ Female Relationship To Patient: _____

Social Security #: _____ Co-Payment Amount: $_____ Plan Effective Date: _____

***Secondary Insurance Section:***

Company Name: _____ Phone #: _____

Claims Address: _____

Policy Number: _____ Group #: _____

Name of Policy Holder: _____ Employer: _____ Policy Holder's Birth Date: _____ Sex:

○ Male ○ Female Relationship To Patient: _____ Social Security #: _____

Co-Payment Amount: $___ Plan Effective Date: _____

***Referring and Primary Care Physician Section:***

Referring Physician (RP): _____ RP Phone #: _____

Primary Care Physician (PCP): _____ PCP Phone #: _____

***Referral Information Section:***

How were you referred to our practice?: ○ Primary Care Physician ○ Other Physician ○ Our web site ○ Friend ○ Relative

○ Emergency Room ○ Hospital (Please specify): _____ ○ Other: (Please specify): _____

***Pharmacy Information:***

Pharmacy preference: _____ Phone Number: _____

Address: _____

# DIGESTIVE DISEASE ASSOCIATES

SPECIALIZING IN DIAGNOSING AND TREATING GASTROINTESTINAL, BILIARY AND LIVER CONDITIONS

## MEDICAL HISTORY FORM

*Instructions: This questionnaire will assist us in understanding your medical condition. Please answer all the questions fully and print legibly. If you are uncertain about any questions, please use a question mark (?)*

Patient Name:_____ DOB:_____ Age:_____

Referring Physician: _____ Primary Care Physician:_____

Day Time Telephone Number:_____ Last four digits of Social security # _____

Primary Language □ English □ Spanish □ Hindi □ Chinese □ Korean □ Other _____

CHECK IF YOU ARE HERE FOR ONE OF MORE OF THE FOLLOWING EXAMINATIONS:

□ **Direct Access Colonoscopy Screening** (procedure only)
□ **Screening Colonoscopy** (1 visit and then procedure)
□ **For Upper Endoscopy Exam**

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR YOUR VISIT:

□ Not experiencing any of the below conditions
□ Are you constipated?
□ Average # of bowel movements per day _____
□ Average # of bowel movements per week _____

| | Date of Onset | | Date of Onset |
|---|---|---|---|
| □ Abdominal pain | _____ | □ Difficulty Swallowing | _____ |
| □ Abnormal CT scan or ultrasound | _____ | □ Excessive belching | _____ |
| □ Abnormal liver enzymes | _____ | □ Heartburn / GERD | _____ |
| □ Anemia | _____ | □ Hepatitis / Jaundice | _____ |
| □ Black, tarry stools | _____ | □ Incontinence of stool | _____ |
| □ Bloating / Gas | _____ | □ Nausea and/or vomiting | _____ |
| □ Blood in stool on test | _____ | □ Painful swallowing | _____ |
| □ Change in bowel habits | _____ | □ Rectal bleeding | _____ |
| □ Chest pain | _____ | □ Vomiting blood | _____ |
| □ Constipation | _____ | □ Weight loss | _____ |
| □ Diarrhea | _____ | □ OTHER | _____ |

**PAST MEDICAL ILLNESSES** Check if you have a history of any of the following. Please check all that apply.

□ NONE

**Gastrointestinal**

□ Barrett's Esophagus
□ Celiac Disease
□ Cirrhosis
□ Colon Cancer
□ Colon Polyps
□ Crohn's Disease
□ Diverticulitis
□ Diverticulosis
□ Fatty Liver
□ Hiatal Hernia
□ H. Pylori
□ Irritable bowel (IBS)
□ Pancreatitis
□ Stomach Ulcer
□ Ulcerative Colitis
□ Other: _____

**Cardiovascular**

□ Atrial Fibrillation
□ Chest Pain
□ Congestive Heart Failure
□ Coronary Artery Diseases
□ Extra Heart Beats (PVC)
□ Heart Attack
□ High Blood Pressure
□ Slow Heart Beat
□ Supraventricular Tachycardia

**Pulmonary**

□ Asthma □ Emphysema (COPD)
□ *I Use CPAP Machine* □ Sleep Apnea □ Other: _____

**Neuropsychiatric**

□ Stroke □ Other: _____
□ TIA (mini-stroke)

**Hematologic**

□ Bleeding Disorders □ Low Platelets
□ Clotting Disorders □ Other: _____

**Endocrine**

□ Diabetes □ Other: _____
□ Insulin Pump

**Genitourinary**

□ Kidney Disease □ Renal Failure
□ Other: _____

**Oncology**

□ Any malignant tumors not previously mentioned

**DIAGNOSTIC TESTS** Check the boxes below if you have had any of the following tests and indicate the date.

□ NONE

| | | | |
|---|---|---|---|
| □ Barium Enema | Date: _____ | □ MRI (abdomen/pelvis) | Date: _____ |
| □ Colonoscopy | Date: _____ | □ Ultrasound (abdomen) | Date: _____ |
| □ CT scan (abdomen/pelvis) | Date: _____ | □ Upper Endoscopy (EGD) | Date: _____ |
| □ Flexible Sigmoidoscopy | Date: _____ | □ Upper GI Series | Date: _____ |

**PAST SURGICAL HISTORY** Check the boxes below if you have had any of the following surgeries and indicate the year.

□ NONE

| | YEAR | | YEAR | | YEAR |
|---|---|---|---|---|---|
| □ Appendix Surgery | _____ | □ Gall Bladder Removal | _____ | □ Hernia Repair | _____ |
| □ Back/Spine Surgery | _____ | □ Heart Catherization | _____ | □ Hysterectomy | _____ |
| □ Bariatric Surgery | _____ | □ Heart Defibrillator | _____ | □ Neck Surgery | _____ |
| □ Breast Surgery | _____ | □ Heart Pacemaker | _____ | □ Rectal Surgery | _____ |
| □ Heart Bypass | _____ | □ Heart Stenting | _____ | | |
| □ Other: | _____ | □ Heart Valve Replacement | _____ | | |

**ALLERGIES** List allergies to all medications (including over-the-countermedications)

□ NONE Indicate reaction to allergy (ie. rash, hives, shock, etc.) and if hospitalized for treatment.

| **Medication** | **Reaction** | |
|---|---|---|
| _____ | _____ | Hospitalized**?** □ Yes □ No |
| _____ | _____ | Hospitalized**?** □ Yes □ No |

Check all statements which apply

□ I have had prior difficulties with anesthesia □ Antibiotics required prior to surgery
□ I have a latex allergy □ I have an allergy to Iodine or IV Contrast?

**MEDICATION LIST**
□ NONE

List medication names, doses and how often taken. Include "over-the-counter" medications. If unable to complete this section, bring all medications with you to your appointment.

| Medication Name | Dose | How often taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**If on a blood thinner, please check** □ Coumadin □ Warfarin □ Plavix □ Pradaxa □ Other

## FAMILY HISTORY

| □ NONE | Relationship + Age at Diagnosis | | Relationship + Age at Diagnosis |
|---|---|---|---|
| □ Breast Cancer | | □ Liver Cancer | |
| □ Celiac Disease | | □ Ovarian Cancer | |
| □ Colon Cancer | | □ Pancreatic Cancer | |
| □ Colon Polyps | | □ Stomach Cancer | |
| □ Crohn's Disease | | □ Thyroid Cancer | |
| □ Esophageal Cancer | | □ Ulcerative Colitis | |
| □ Kidney Cancer | | □ Uterine Cancer | |

## Please sign and date:

**Patient Signature** **Date**

# DIGESTIVE DISEASE ASSOCIATES

## FINANCIAL POLICY, RECORD AND MEDICATION HISTORY RELEASE AND HIPPAA ACKNOWLEDGEMENT

- **For patients with insurance:** Co-payments, coinsurance and/or deductibles are the responsibility of the patient orresponsible party and due at the time of service. It is the patient's responsibility to obtain a written referral and authorization if their insurance carrier requires the same. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.
- **For patients without insurance:** I understand that payment for services rendered by DDA is due and payable in full at the time services are rendered, unless prior arrangements have been made with an employee ofDDA.
- **In the event** the Patient submits payment by check and that check is returned for any reason by the Bank, DDA will add $30.00 to the balance owed by the Patient or Responsible Party.
- **No statement by an employee** or agent of DDA will contradict, void, or nullify this Agreement, nor shall the patient rely on any statements or opinions made by DDA that Patient's insurance carrier will pay the bill.
- **Payments:** Unless other arrangements are approved by DDA in writing, the balance on your statement is due and payable when the statement is issued, and past due if payment is not received within 60 days after adjudication by your insurancecarrier.
- **Past due accounts:** If your account becomes past due, we will take the steps necessary to collect this debt. If we have to refer your account to a collection agency and/or an attorney, you agree to pay all of the collection costs that are incurred, including attorney fees and court costs, if applicable. Any balance unpaid after 60 days from the date services were rendered will be subject to interest at the annual percentage rate of 18% percent
- **Waiver of confidentiality:** You understand if your account is submitted to an attorney and/or collection agency, if DDA has to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and that your account is delinquent with DDA will become a matter of public record.

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**I give my consent for treatment** and authorize the release of clinical information to other medical professionals who have need of such use for the provision of my care. **I hereby authorize DDA** to release all medical and billing information necessary to secure payment from any insurance carrier on my behalf. **Authorization is hereby given to** DDA to submit all claims directly to my insurance company on my behalf and authorize my insurance carrier to forward payment directly to DDA.

### CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

(Please provide information below on how we should contact you)

I hereby authorize DDA to communicate information regarding my evaluation, diagnosis, treatment and billing to/with:

- My spouse/family member/other Name:_____ _____Initials
- My spouse/family member/other Name:_____ _____Initials
- If, when calling, we reach an answering machine or voicemail message, may we leave a message? ○ **Y** ○ **N**_____Initials

### AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I authorize DDA to obtain my medication history from community pharmacies and/or Pharmacy Benefit Managers for the purpose of my treatment.

### AUTHORIZATION AND ACKNOWLEDGEMENT

By my signature affixed below, I acknowledge that I have read and agree to comply with the Financial Policy for Digestive Disease Associates as described above, that I give my authorization as described in the section titled Authorization for Release of Medical Records, that I have provided the information as requested in the section titled Confidential Communication of Personal Health Information, that I give authorization to DDA to obtain my Medication History as indicated above and that I have received a copy of the Digestive Disease Associates Notice of Privacy Practices.

_____ _____

Signature of Patient or Parent/Guardian, if minor | Date

_____ _____

If Responsible Party, Please Print Name | Relationship to Patient

_____ _____

Witness | **Account # for Office Use**

# DIGESTIVE DISEASE ASSOCIATES

## APPOINTMENT CANCELLATION / NO- SHOW POLICY

Digestive Disease Associates is privileged to provide medical and endoscopic treatment for our patients. We work diligently to maintain a high level of professional and personalized service. We strive to accommodate our patient's needs for office visits and procedures in a timely manner. This requires careful planning and coordination amongst many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment or procedure without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelled appointments without adequate notice. This policy will also apply to scheduled procedures but the monetary consequences will be greater. We respectively request your understanding and agreement to our policy as is stated below.

## OFFICE VISITS

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours in advance of their appointment will be charged a fee of $50.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday. If an established patient fails to keep three appointments or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

## PROCEDURES

Any patient who fails to keep an appointment for a procedure (upper endoscopy, colonoscopy, flexible sigmoidoscopy, endoscopic retrograde cholangiopancreatography) or remicade infusion; or who cancels or reschedules an appointment less than 48 hours in advance of their procedure or infusion will be required to pay $100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Thursday.

If an established patient fails to keep two appointments or fails to give adequate notice on two occasions, their primary care physician will be notified and the practice will have the right to dismiss that patient from the practice.

## FEES

All fees charged by Digestive Disease Associates pursuant to this No- Show / Cancellation Policy are not payable by your insurance company.

All fees are payable on or at your next office appointment with your Digestive Disease Associates physician or within 30 days of receipt of billing statement from Digestive Disease Associates for that fee, whichever is earlier.

If you believe you were charged this no- show fee in error, we allow 30 days from the appointment to dispute this charge in writing:

Email: Please send the email through the website www.DDAMD.com
Select the Contact Us tab (at the top) and then Question about a bill or payment in order to access the Billing Question Form for submission.

(Please enter your doctor's name in the subject line of the e-mail)

Standard Mail: Digestive Disease Associates
Attention: Director of Operations
700 Geipe Road
Suite 201
Catonsville, MD 21228

Please remember that it is your responsibility to make certain that we have updated and/or accurate phone numbers and addresses so that we may contact you promptly.

Thank you for your consideration and understanding of our policy.

Patient signature:_____ Date: _____

# DIGESTIVE DISEASE ASSOCIATES

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

Effective Date: May 27, 2013
This Notice was revised on: November 26, 2015.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Chief Operating Officer (COO)
Mailing Address: 700 Geipe Road, Ste. 201, Catonsville, MD 21228
Telephone: (410) 737-8125
Fax: (410) 737-6884
Email: compliance@ddamd.com

**About This Notice**

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

**What is Protected Health Information?**

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

**How We May Use and Disclose Your Protected Health Information**

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

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

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

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

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

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

**Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at

Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the

purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Your Written Authorization is Required for Other Uses and Disclosures**

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

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

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

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

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

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

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

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or

friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

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

  violation of that restriction unless it is needed to provide emergency treatment.

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

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

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

**How to Exercise Your Rights**

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

**Changes To This Notice**

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

**Complaints**

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.