Name _____ Date of Birth _____ Date _____

NEW PATIENT REGISTRATION

Patient Full Name _____ Date of Birth _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced Social Security No. _____

Primary Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Occupation _____

Employer _____ Phone _____

Employer's Address _____

How did you hear about us? ☐ Dr. Referral ☐ Friend or Family ☐ Website ☐ Other _____

Name of Spouse or Parent _____ Phone _____

Occupation _____ Employer _____

Employer's Address _____

☐ Designate as Emergency Contact

Other Emergency Contact Name _____ Phone _____

WE DO NOT ACCEPT MEDICAID

Medical Insurance _____ Phone _____

Group No. _____ ID/Policy No. _____ Group Name _____

Subscriber Name _____ Date of Birth _____

If insurance through an employer, please list employer name _____

Other Medical Insurance _____ Phone _____

Group No. _____ ID/Policy No. _____ Group Name _____

Subscriber Name _____ Date of Birth _____

If insurance through an employer, please list employer name _____

FOR STAFF USE ONLY

Do we accept this insurance?	YES or NO	Deductible _____
Is insurance active?	YES or NO	Copay _____
Does PT have to use specialty lab?	YES or NO	

Name _____ Date of Birth _____ Date _____

HEALTH HISTORY

Please list all your current medications; include *Medicine, Dose, Prescribed By*

_____

_____

_____

_____

_____

Drug Allergies _____

Medical problems you have been diagnosed with:

_____

_____

_____

_____

Previous Primary Care Doctor _____

Specialists who are following you care (include physician name and specialty)

_____

_____

Previous Surgeries_____

_____

Are you planning to get pregnant or breast feed? ☐ Yes ☐ No

Do you smoke or use any type of tobacco? ☐ Yes ☐ No

If yes, Type: _____ Packs/Cans per day _____ # of years _____

Do you drink alcohol: ☐ Yes ☐ No If yes, how many drinks per week? _____

FAMILY HEALTH HISTORY

Father _____

Mother _____

Siblings _____

Name _____ Date of Birth _____ Date _____

REVIEW OF SYSTEMS

Have you had any of the following:

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Always cold
- ☐ Daytime sleepiness

EYES
- ☐ Eyeglasses
- ☐ Contact lenses
- ☐ Blurred vision
- ☐ Visual changes

ENT
- ☐ Nasal discharge
- ☐ Post nasal drip
- ☐ Snoring
- ☐ Sleep apnea

RESPIRATORY
- ☐ Tightness
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Chest pressure
- ☐ Palpitations
- ☐ Heart Attacks
- ☐ Coronary Artery Disease
- ☐ Heart Valve Disease
- ☐ Heart Failure
- ☐ Edema

HEME/LYMPH
- ☐ Bruising
- ☐ Blood clots
- ☐ Peripheral edema
- ☐ Enlarged lymph nodes

ALLERGIC/IMMUNE
- ☐ Sneezing
- ☐ Hives
- ☐ Seasonal allergies
- ☐ Frequent illnesses

MSK
- ☐ Knee pain
- ☐ Hip Pain
- ☐ Ankle pain
- ☐ Back pain

DERMATOLOGY
- ☐ Skin tags
- ☐ Acne
- ☐ Hirsutism
- ☐ Dry skin
- ☐ Hair loss

GENITOURINARY
- ☐ Decreased flow
- ☐ Heavy menses
- ☐ Irregular menses
- ☐ Partial voiding
- ☐ Incontinence
- ☐ Nightly urination
- ☐ Urinary urgency
- ☐ Urinary frequency
- ☐ Kidney Stones
- ☐ Kidney Disease

NEUROLOGY
- ☐ Headache
- ☐ Tingling
- ☐ Numbness
- ☐ Dizziness
- ☐ Seizures
- ☐ Strokes

PSYCHIATRIC
- ☐ Depression
- ☐ Can't feel pleasure
- ☐ Rapid eating
- ☐ Anxiety
- ☐ Poor focus
- ☐ Insomnia
- ☐ Irritability
- ☐ Racing thoughts
- ☐ Impulsive behavior
- ☐ Carb/sweet cravings
- ☐ Compulsive behavior

ENDOCRINE
- ☐ Hypoglycemia
- ☐ Excessive hunger
- ☐ Anorexia
- ☐ Pancreatitis
- ☐ Pancreatic Cancer
- ☐ Medullary Thyroid Cancer

GI
- ☐ Heart burn
- ☐ Constipation
- ☐ Nausea
- ☐ Abdominal pain

LAST EVALUATION COMPLETED

	DATE	NAME & LOCATION ORDERED
Colonoscopy	_____	_____
Mammogram	_____	_____
Hemoglobin A1C	_____	_____
Microalbumin	_____	_____

OFFICE POLICIES

CANCELLATION & LATE ARRIVAL POLICY

We understand that you may be late or unavailable for your scheduled appointments, so please give us a call as soon as possible to reschedule. I agree to the policies below and understand if these policies are broken on a regular basis, the physician will review my case and I maybe dismissed from the Practice.

10-Minute Reschedule Policy

Patients checking in more than 10 minutes after their scheduled appointment time will be rescheduled.

24-Hour Cancellation/No-Show Policy

Appointments cancelled less than 24-hours in advance may be subject to a $25.00 rescheduling fee (will not be covered by insurance).

Signature _____ Date _____

PHOTOGRAPHY ADVERTISING CONSENT

We believe a picture is worth a thousand words. We are seeking your permission to use before and after pictures to document your success. We would like to use a photo, taken up to 12 months before starting your weight loss program or taken at your first visit, at regular intervals throughout the program, and upon reaching your weight loss goal. Pictures may be used on our website or other advertisements. We will only use your first name. We may modify the picture(s) using cropping, color correction, and red eye correction and we may add comments such as, “Anne lost 30lbs!”

☐ Yes, I give my permission to The Internal Medicine Clinic to use my before, progress, and after weight loss photograph(s) for advertising purposes.

☐ No, I do not wish to use my photograph(s) for advertising purposes.

Signature _____ Date _____

MEDICAL AUTHORIZATION

I, the undersigned, do hereby request and give my consent for any physician associated with the Internal Medicine Clinic to release to my insurance company/companies any protected health information necessary for treatment, payment, or health care operations to the application of my insurance claim. I understand this consent may be revoked by me, in writing, at any time.

I, the undersigned, do hereby request that all benefits payable for medical services rendered be paid directly to the Internal Medicine Clinic.

I understand that I am financially responsible to you for all of my individual charges incurred during the course of treatment, including hospitalization, even though I may have insurance or other third-party coverage. I recognize that the cost of this medical care may exceed the amount reimbursed by my insurance company. I understand that I will be expected to pay the amount set forth on the physicians fee schedule regardless of what my insurance company may consider usual and customary (exception is noted for medicare and all PPO contracts). I promise to pay this amount when due. In the event of default, I recognize that legal proceedings may result and I agree to pay the cost of collection including reasonable attorney's fees.
A photostatic copy of this consent and assignment shall be considered as effective and valid as the original, and I do hereby consent for duplication of the original whenever necessary for insurance purposes.

I, the undersigned, do hereby acknowledge that I have a complete understanding of the contents herein and that my signature below makes this a valid and legal document.

Signature _____ Date _____

THE INTERNAL MEDICINE CLINIC, LLC.
PATIENT HIPAA ACKNOWLEDGEMENT & CONSENT

_____ (Patient initials) **NOTICE OF PRIVACY PRACTICES**
I acknowledge that I have received the IMC's Notice of Privacy Practices (pages 13-16), which describes the ways in which the practice may use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Practice's Notice of Privacy Practices.

_____ (Patient initials) **CONSENT TO TREAT**
I authorize IMC and staff to provide medical services to me and authorize the disclosure of protected health information for purposes of payment, health care operations and treatment. This includes communication with my physicians, pharmacist, and hospitals by letter, phone, or fax. I understand that I have the right to request treatment, payment, and healthcare operations, and the IMC may refuse this request. I understand that unless the IMC has taken action in reliance on such consent that I may revoke this consent, by giving written notice.

_____ (Patient initials) **MEDICARE POLICY**
I request that payment of authorized Medicare and Medigap benefits be made on my behalf to IMC for service items furnished to me by the physicians of IMC. I authorize any medical information about me to be released to Center for Medicare Services, it's agents, my Medigap carrier, and/or benefits-payable related services. I understand this is a lifetime authorization and that I may revoke authorization at any time in writing.

_____ (Patient initials) **DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS**
I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we require written authorization. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient initials) I wish to designate the following family member/friend to pick up an order or prescription on my behalf:

Name _____ Date _____

E-prescribe all my prescriptions to _____
(Pharmacy Name/Location)

Signature _____ Date _____

Name _____ Date of Birth _____ Date _____

THE INTERNAL MEDICINE CLINIC, LLC.
PATIENT HIPAA ACKNOWLEDGEMENT & CONSENT

CONSENT TO VOICEMAIL, TEXT MESSAGE & EMAIL COMMUNICATION

Patients in our health center may be contacted via voicemail, text message and/or email to:

- remind you of an appointment
- provide general health reminders/information, including prescription medication information
- share lab or test results
- obtain feedback on your experience with our healthcare team

If at any time I provide a phone number or email at which I may be contacted, I consent to receiving healthcare communication at that phone number or email from the IMC, unless revoked in writing.

The IMC does not charge for this service, but standard text messaging rates may apply as detailed in your wireless plan (contact your carrier for pricing plans and details).

Signature _____ Date _____

Revocation

_____ I hereby revoke my consent to receive any future appointment reminders, feedback, and general health via voicemail.

_____ I hereby revoke my consent to receive any future appointment reminders, feedback, and general health via text messages.

_____ I hereby revoke my consent to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Signature _____ Date _____

Name _____ Date of Birth _____ Date _____

THE INTERNAL MEDICINE CLINIC, LLC.
BILLING POLICY

Ralph Aquadro, M.D. David E. Bachofer, M.D. Seth Jarrell, M.D. Tiler Williams, D.O.

Our goal is to provide and maintain a positive physician-patient relationship. Providing you with our financial policy in advance allows for a good flow of communication and enables us to operate efficiently. To prevent misunderstanding between patients and our practice, The Internal Medicine Clinic, LLC. adheres to the following patient financial policy. Your complete understanding of your financial responsibilities is an essential element of the physician-patient relationship and continued medical management.
Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- Full payment is due at the time of service for co-pays, deductibles, and coinsurance. For your convenience we accept cash, personal check, credit card, and money orders. The Practice is required to collect payment based on your benefit contract in the Practice's contractual agreement with your insurance carrier. The Practice must collect co-pays at the time of service and is required to report to the carrier any enrollees failure to pay the co-pay.
- It is your responsibility to provide the Practice with current, accurate insurance information at check-in and to notify the Practice of any changes to this information. A valid insurance card, picture ID, and social security number of the adult insured (policy holder and guarantor your of bill) must be presented at the time of service.
- It is the patient's responsibility to understand insurance carrier coverage limitations (i.e. preventative, out of network benefits, prior authorization, and referral requirements) and member out-of-pocket financial requirements (copay, deductible, and coinsurance). The amount of your co-pay maybe different for specialists than for primary care.
- If the Practice does not participate with your insurance or you do not have medical insurance, you are expected to pay in-full at the time of service. The Practice may provide assistance in filing the charges to your insurance company; however, payment is expected at the time of service.
- If you have Medicare Part B only, you are responsible for your Medicare deductible and your 20% coinsurance at the time of service.
- Patients will receive a separate bill from Quest labs for blood and urine tests that are unable to be performed in our office. Questions about these bills should be directed to Quest.
- The Practice does not accept postdated checks. Checks written to the Practice that are canceled or returned for non-sufficient funds will be assessed a $35 fee. To rectify your account, you will be required to pay with cash, money order, cashiers check, or credit card before your next appointment.
- There is a charge for completion of FMLA and disability forms, due at pick-up.
- Patients are billed for any patient responsibility (coinsurance/deductibles/non-covered services) as determined on the Explanation of Benefits (EOB) from your carrier. If you have a balance after your insurance payment, we will mail an updated statement. If full payment is not received by the due date, the patient is placed in "collection status," and a second statement will be mailed. Patients in "collection status" may be referred to an outside collection service. Payment plans are available for balances over $100. Patients are responsible for any collection or legal expenses associated with collection efforts.
- Patients with collections balances will not be permitted to schedule appointments until their account balances are current, unless other payment arrangements are made prior to visit.
- The Practice reserves the right to charge a $25 fee for patients canceling an appointment less than 24-hours in advance.

My signature below confirms that I have read these billing policies and understand my financial obligation as pertains to The Internal Medicine Clinic, LLC.

Signature _____ Date _____

THE INTERNAL MEDICINE CLINIC, LLC.
NOTICY OF PRIVACY PRACTICES

Effective Date: April 15, 2002. Revised: January 7, 2023.

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

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

Mailing Address: 204 Ana Drive Suite B, Florence, AL 35630
Telephone: 256-767-5940, Fax: 256-767-5943

ABOUT THIS NOTICE

We are required by law to maintain the privacy of Protected Health Information (PHI) 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 PHI; 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 (PHI)?

Protected Health Information (PHI) 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 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 PHI

We may use and disclose your PHI in the following circumstances:

FOR TREATMENT We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

FOR PAYMENT We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

FOR HEALTH CARE OPERATIONS We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

APPOINTMENT REMINDERS/TREATMENT ALTERNATIVES/HEALTH-RELATED BENEFITS AND SERVICES We may use and disclose PHI 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 PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

PERSONAL REPRESENTATIVE If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

AS REQUIRED BY LAW We will disclose PHI about you when required to do so by international, federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SATETY We may use and disclose PHI 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.

THE INTERNAL MEDICINE CLINIC, LLC.
NOTICY OF PRIVACY PRACTICES

BUSINESS ASSOCIATES We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consultation services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

ORGAN AND TISSUE DONATION If you are an organ or tissue donor, we may use or disclose your PHI 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 release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

WORKERS' COMPENSATION We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS We may disclose PHI 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; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) 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 PHI 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.

LAWSUITS AND DISPUTES If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI 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 PHI to defend ourselves if you sue us.

LAW ENFORCEMENT We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

NATIONAL SECURITY We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS We may release PHI 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 PHI 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.

MEDICAL RESIDENTS AND MEDICAL STUDENTS Medical residents or medical students may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

NEWSLETTERS AND OTHER COMMUNICATIONS We may use our PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

THE INTERNAL MEDICINE CLINIC, LLC.
NOTICY OF PRIVACY PRACTICES

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 We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

DISASTER RELIEF We may disclose your PHI to disaster relief organizations that seek your PHI 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.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI 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 PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked will not be affected by the revocation.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, AND GENETIC INFORMATION

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights, subject to certain limitations, regarding your PHI:

RIGHT TO INSPECT AND COPY You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. However, you do not have a right to inspect or copy psychotherapy notes. We may charge you a 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 ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS If your PHI is maintained in one or more designated record sets electronically (for example 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 may charge you a reasonable cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

RIGHT TO RECEIVE NOTICE OF A BREACH We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

RIGHT TO REQUEST AMENDMENTS If you feel that PHI 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. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (4) is accurate and complete. It we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

THE INTERNAL MEDICINE CLINIC, LLC.
NOTICY OF PRIVACY PRACTICES

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 PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and healthcare operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. Your must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). 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 you 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 PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

RIGHT TO RESTRICT CERTAIN DISCLOSURES TO YOUR HEALTH PLAN You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

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 special 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. You can get a copy of this Notice at our office.

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 get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

CHANGES TO THIS NOTICE

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human services. 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.

Name _____ Date of Birth _____ Date _____

NEW PATIENT REGISTRATION INSTRUCTIONS

- Download **New Patient Registration** Form.
- **Print the form** and fill out each page,
- When complete, **drop-off, mail,** or **fax forms**.

Address - 204 Ana Dr. Florence, AL 35630

Phone - (256) 767-5940 - Fax - (256) 767-5943

TheInternalMedicineClinic.com