HONOR COMMUNITY HEALTH
PATIENT INTAKE FORM

Thank you for selecting us. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION *(Confidential)*							
Today's Date		Last Name		First		M.I.	
Date of Birth		Social Security No.		- -			
Street Address				Apartment/Unit#			
Mailing Address							
City		State		ZIP Code			
Home Phone		Work Phone		Cell Phone			
Parent or Guardian Name		Relationship?					
May we text you with appointment reminders and information regarding your healthcare? ☐ Yes ☐ No *Standard data fees & text message rates may apply based on your mobile phone carrier.							
Email address for use in HCH Patient Portal ☐ Yes ☐ No Is it OK to e-mail information? ☐ Yes ☐ No		Email					
Gender at Birth	☐ Female ☐ Male	Current Gender	☐ Female ☐ Transgender Male (Female to Male) ☐ Male ☐ Transgender Female (Male to Female) ☐ Other ☐ Choose not to disclose				
Sexual Orientation	☐ Straight/Heterosexual ☐ Something else ☐ Lesbian or Gay ☐ Don't know ☐ Bisexual ☐ Choose not to disclose						
Race *(Please check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian ------- If yes, please check: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander---- If yes, please check origin: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ White/ Caucasian ☐ Refuse to report						
Ethnicity	☐ Hispanic/Latino ---- If yes, please check origin: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Not Latino/Hispanic ☐ Refuse to report						
Language you are most comfortable with:	☐ English ☐ Spanish ☐ Other (please specify) _____						

Patient Name: _____ Date of Birth: _____

Marital Status:	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed
Please tell us about your living situation: All information is confidential.	☐ I / we own or rent home/ apartment ☐ I / we have been homeless in the last year and have housing now (Transitional) ☐ Staying with friends/relatives because I have no other choice (Doubling Up) ☐ Staying in a shelter (Short term housing like HOPE, SOS, Haven, etc.) ☐ Staying in a treatment facility (Transitional) ☐ Living on the street, outdoors, or in a car/travel trailer/camper (Street) ☐ Living somewhere not meant to be a home – no running water or heat (Other homeless) ☐ Other: _____ Have you been homeless at any time in the past 12 months? ☐ Yes ☐ No Date: _____ Are you worried about losing your housing? ☐ Yes ☐ No
Military Status	☐ Active Duty Military ☐ Retired Military ☐ Veteran
Employment Status	☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ FT Student Student, what school do you attend? _____ ☐ PT Student
Employer	Occupation
If employed in agriculture:	☐ Migrant ☐ Seasonal ☐ Employed Year Round
Preferred Pharmacy	Pharmacy Name: _____ Pharmacy Address: _____ Pharmacy Phone Number: _____
Advanced Directive	Do you have an Advanced Directive? ☐ Yes ☐ No If No, would you like more information on this? ☐ Yes ☐ No
Do you receive services from any of the following agencies?	☐ Community Network Services (CNS) ☐ Training and Treatment Innovations (TTI) ☐ Easter Seals (ES) ☐ Community Living Services (CLS) ☐ Oakland Family Services (OFS) ☐ Community Housing Network (CHN) ☐ Common Ground ☐ Macomb Oakland Regional Center (MORC) ☐ None

Please tell us how you heard about Honor Community Health_____

Honor Community Health is dedicated to ensuring you have access to our services and our staff is available to assist you in determining if you are eligible for a variety of health benefit coverage options. No one is denied care due to inability to pay. These options may include ability to pay based on sliding fee discounts, special grant-provided services or public-funded health care coverage. In many cases, our staff can assist qualifying patients with the enrollment or assessment process. Honor Community Health offers discounted fees for qualified patients who may be unable to pay the full fee for services. As a non-profit organization, we receive funding from local, state, federal and grant funding sources and we are required to collect financial information from our patients to continue to receive this funding. All information will remain confidential. By declining to provide the requested financial information, you will be ineligible for financial assistance for your care.

Patient Name: _____ Date of Birth: _____

What is your total household income? (This is confidential and only reported anonymously) ☐ 0 - $10,000 ☐ $30,001 - $40,000 ☐ $10,001 - $20,000 ☐ $40,001 - $50,000 ☐ $20,001 - $30,000 ☐ $50,001 or more	How many family members live in your household? _____
☐ I chose not to answer the above questions about my household income and individuals in home.	

EMERGENCY CONTACT					
Name		Relationship			
Home Phone		Cell Phone		City/State	

CURRENT HEALTHCARE PROVIDER		
Do you have a previous Medical Care Provider?	☐ Yes ☐ No	*If Yes – please list:*
Do you have a Dentist?	☐ Yes ☐ No	*If Yes – please list:*

PRIMARY INSURANCE *(you will be asked to show your card at the appointment)*

Name of Policy Holder _____

Insurance Company Name_____Policy Start Date _____

Policy/ID Number_____Group/Plan Number _____

Claims Address _____

City_____State_____Zip_____

SECONDARY INSURANCE – if appropriate *(you will be asked to show your card at the appointment)*

Name of Policy Holder _____

Insurance Company Name_____Policy Start Date _____

Policy/ID Number_____Group/Plan Number _____

Claims Address _____

City_____State_____Zip_____

FOR OFFICE USE ONLY	***Date Entered***		***Staff Initials***	

Patient Name: _____ Date of Birth: _____

HEALTH HISTORY FORM

Have you ever been hospitalized, other than for surgery?
☐ Yes ☐ No *If Yes, please specify below*

Reason for Hospitalization	Date
_____	_____
_____	_____

Have you been to the emergency room in the last 12 months?
☐ Yes ☐ No *If Yes, please specify below*

Reason for Emergency Room Visit	Date
_____	_____
_____	_____

Past Surgeries	Medical Problems / Conditions / Illness	Date
_____	_____	_____
_____	_____	_____

Please list all doctors you have seen in the last 12 months:

_____ _____
_____ _____
_____ _____

Please list all medications that you are currently taking including: prescriptions, over the counter, and herbal/holistic medications. Please list dose and amount. *(If you need more space, please use the back of this sheet)*

_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies? (Food, medication or environmental allergies)
☐ Yes ☐ No *If Yes, please specify below*

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Have you or any blood relative had: (Please write who was diagnosed i.e. brother, sister, aunt, uncle, children)

	Myself	Relative (specify)
Diabetes	☐	☐ _____
Blood Clots	☐	☐ _____
High Blood Pressure	☐	☐ _____
Kidney Disease	☐	☐ _____
Heart Disease	☐	☐ _____
Lung Disease	☐	☐ _____
Cancer	☐	☐ _____
Epilepsy	☐	☐ _____
Arthritis	☐	☐ _____
Alcoholism	☐	☐ _____

	Myself	Relative (specify)
Mental Illness	☐	☐ _____
Hepatitis	☐	☐ _____
HIV	☐	☐ _____
Drug Use	☐	☐ _____
Colo-Rectal Cancer	☐	☐ _____
Rectal Polyps	☐	☐ _____
Tuberculosis	☐	☐ _____
Osteoporosis	☐	☐ _____
Other	☐	☐ _____

Patient Name: _____ Date of Birth: _____

Please circle (Y) Yes or (N) No:

Do you drink caffeine drinks?	Y / N
Do you exercise regularly?	Y / N
Do you urinate often?	Y / N
Do you feel you are overweight or underweight?	Y / N
Have you had a physical in the last year?	Y / N
Have you had a flu shot in the last 12 months?	Y / N
Have you ever tested positive for Tuberculosis (TB)?	Y / N
Do you see a dentist at least once a year?	Y / N
Do you have reliable transportation?	Y / N
Do you have any trouble taking or getting your medications?	Y / N
Do you have trouble/difficulty with daily activities?	Y / N
Do you feel safe at home?	Y / N
Have you ever used tobacco?	Y / N
Do you currently use tobacco?	Y / N
If yes, for how long _____ years?	
Do you use drugs? (Marijuana, cocaine, heroin, etc.)	Y / N
Do you drink alcohol?	Y / N
If yes, how many times per week? _____	

FOR WOMEN

Date of last menstrual period: _____	
Date of last Pap smear: _____	
Have you ever had an abnormal Pap smear?	Y / N
Date of last mammogram: _____	
Have you ever had an abnormal mammogram?	Y / N
Do you check your breasts for lumps monthly?	Y / N
If you are over the age of 50, have you been tested for colon cancer?	Y / N
Was the test abnormal?	Y / N

FOR MEN

Date of last prostate/PSA exam: _____	
Have you ever had an abnormal prostate exam?	Y / N
If you are over the age of 50, have you been tested for colon cancer?	Y / N
Was the test abnormal?	Y / N

List the countries you have visited in the past year: _____

Is there anything else we should know about your health or past medical history?

_____

_____

Do you have any concerns?

_____

_____

This information is confidential. This form is part of the medical record. If you had difficulty completing it or have further comments a staff member can assist you.

Patient Name: _____ Date of Birth: _____

I hereby consent to all treatment, including tests, procedures and medications as deemed necessary by the clinician staff of Honor Community Health. I authorize the release of any information necessary for my ongoing care or to process any insurance claims related to my care. I agree to pay any charges at the time of service or upon receipt of statement. I grant permission for third party auditors to view my private health information as part of Honor Community Health's quality improvement and evaluation process.

Patient or Legal Guardian Signature		**Date**	
Patient name (please print)			
Legal Guardian name (please print)			

Please Note The Following With Regard To Treatment

Honor Community Health staff will depend on statements made by the patient, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment.

Some services at Honor Community Health may be provided with telemedicine equipment and involve interaction with providers who are not physically in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not: videotaped, routed through the Internet, or saved in any way. However, relevant information from your visit will be documented in your medical records, just as it would be if the provider had been physically present.

Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

I consent to Honor Community Health providing, and my receipt of, any and all services available through Honor Community Health's telemedicine platform. I understand that I can revoke this consent at any time by informing Honor Community Health in writing.

Signature_____If signing on behalf of someone else, relationship_____

Date _____

Confidentiality Permission Agreement

I give the person(s) listed below access to my entire Personal Health Information (PHI). I also authorize Honor Community Health to talk about my entire PHI to the person(s) listed below.

Name_____Relationship_____Phone Number_____

Name_____Relationship_____Phone Number_____

I give permission to the individual listed below to bring my children to their health care appointments and pick up medication from the pharmacy.

Name_____Relationship_____Phone Number_____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

HONOR COMMUNITY HEALTH MISSION STATEMENT

To meet the health and wellness needs of vulnerable populations of Oakland County through the provision of comprehensive, integrated primary care.

Thank you for choosing Honor Community Health to serve the health care needs for you and our family. We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider.

As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Agreement.

Please understand that we will make every effort to ensure your visit will be covered with your Health Insurance Plan, however, we cannot guarantee coverage.

All services provided by Honor Community Health may be evaluated for our Sliding Fee Scale, Honor Cares, and if eligible, your charges may be reduced.

Individual's Financial Responsibility Statement

- I understand that I am financially responsible for my health insurance deductible, coinsurance, copayments and any non-covered services as outlined by my health insurance plan.
- Co-payments are due at the time of service.
- In the event my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs associated with the services provided.
- If my health insurance plan requires a referral, I will notify the staff, but understand that I am ultimately responsible for obtaining and bringing the referral to my visit.
- I am responsible to pay the balance on my account before my next visit whether I received a statement in the mail or not.

I have read the above agreement and understand that I am financially responsible for charges not covered by my health insurance plan.

Signature of Patient, Authorized Representative or Responsible Date

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

HONOR COMMUNITY HEALTH
MEMO OF UNDERSTANDING

Thank you for choosing our medical practice as your "Home" base for medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuing, and personal medical care.

In order for this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

PHYSICIAN RESPONSIBILITIES

- Listen to the Patient and/or caregiver about his/her health care concerns, and encourage open communication.
- Provide advice and information on the different treatment plans or prevention programs for the Patient's condition. Provide options for non-urgent communication including electronic access for scheduling office visits and follow-up visits and for obtaining test results and referrals.
- Provide flexible hours, schedule appointments within a reasonable time, and see Patient as closely to the scheduled appointment time as possible.
- Provide telephone availability to Physician for urgent communication 24 hours per day, 7 days per week.
- As technology develops, provide convenient options for non-urgent communications between Patient and Physician including after-hospital support, follow-up visits, and consultations.
- Use a team approach to health care by providing access to other doctors and health care facilities when necessary.
- Combine care provided by my practice and other doctors and health care facilities so as to avoid repetition, delay, and error.
- Communicate test and treatment results quickly and correctly.
- Provide information, recommendations, and advice for preventative care, wellness maintenance, self-management direction, and counseling.
- Send reminders to Patients for follow-up care and preventative care.
- Maintain clinical information in a format that allows for easy search, retrieval, and information transfer while protecting privacy and confidentiality, including participating in the development and maintenance of standardized electronic health records and patient registries.
- Instruct the medical home base staff in the responsibilities described above.

PATIENT/PARENT/CAREGIVER/LEGAL GUARDIAN RESPONSIBILITIES

- Communicate openly and fully with Physician and Physician's staff.
- Participate actively in the development of treatment plans for your/patient's condition and follow agreed-upon treatment plans.
- Provide Physician with feedback regarding you/patient's treatment plan.
- Appear on time for appointments, procedures, and other medical tests at Physician's office, and submit samples and information on time as requested by Physician.
- Schedule and attend follow-up appointments as suggested by Physician.
- Include yourself in the recommendations for maintenance or improvement of your/patient's health and wellness.
- Participate in action planning and goal setting for the maintenance or improvement of your/patient's health and wellness.
- Participate in developing and maintaining a complete health record by giving permission for the delivery and distribution of clinical information to and from doctors and health care facilities.

Please take the time to carefully read this Memo of Understanding. Kindly sign your name in the appropriate place below.

_____ _____

Patient/Caregiver Date

11/2018

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT AND CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Honor Community Health may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Operations (TPO). Please refer to Honor Community Health's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received a copy of, and I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent.

Honor Community Health observes the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Honor Community Health at 461 W. Huron, Pontiac, MI 48341-1601.

With my consent, Honor Community Health may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

Honor Community Health may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

Honor Community Health may email to me appointment reminders and patient statements. I have the right to request that Honor Community Health restrict how it uses or discloses my PHI to carry out the TPO. However, the center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Honor Community Health's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance to my prior consent. If I do sign the consent, Honor Community Health may decline to provide treatment to me.

_____ _____

Signature of Patient or Patient's Legal Guardian (if applicable) Date

_____

Print Patient's Name

_____

Print Name of Patient's Legal Guardian (if applicable)

OFFICE USE ONLY

As of January 16, 2012, all patients must be offered a copy of Honor Community Health's Notice of Oakland Privacy Practices. The patient should acknowledge this by signing above. This form needs to be placed in the registration section of the patient's chart. If the patient cannot sign or refuses to sign, then the registration staff or the medical assistant needs to sign below saying that the Notice was indeed offered to the patient. This only needs to be done once for each patient.

This patient/guardian has been offered a copy of Honor Community Health's Privacy Notice

_____ _____

Signature of Honor Community Health Staff Date

NOTICE OF 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.

When you get care at Honor Community Health your caregivers create a medical record. The medical record has information about your medical history, the tests you had, the care you got and how you responded. We also have billing records. We are required by law to make sure your medical information is kept private, to give you this Notice to tell you how we use and share your medical information, and what your rights are. We will ask for your signature to verify that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date.

A. How We May Use and Disclose Health Information About You

Information that we can share without your permission

We may use medical information about you to provide you with treatment. People who care for you need to know about your health problems so that they can give you safe and complete care. These people include doctors, nurses, mental health providers, dentists, health students/residents/interns, home health agencies, nursing homes, laboratories, hospitals, equipment providers, or others we use to provide services that are part of your ongoing care.
Some examples of how we may use and share information are:

- If you have diabetes, the nutritionist needs to know this to help you plan safe meals.
- If you are admitted to the hospital, we may share information with the hospital to help with your care.
- Coordinate a comprehensive health/mental health treatment plan with a mental health provider.

We may share medical information about you so that we can get paid for your care. For example, we may share your information with your insurance company so that we get paid for your health care. We may also share it to get an okay from your insurer before you receive a certain treatment (prior approval). That way, we know they will pay for your care.

We may use and share medical information about you as part of improving care to all patients. For example, to train doctors or other healthcare workers and students, or to look at how your care went and how we can improve care in the future. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements.

We may use or share information about you because you get care here:

- to contact you about an appointment or because you missed an appointment;
- to ask you for a donation to Honor Community Health. Please contact us if you do not want to get these requests;
- to tell someone who helps pay for your care;
- to tell your relatives, close friends or others involved in your care, but only if you say that it is okay for us to share this information. If you are unable to say okay, we will do what we think is in your best interests;
- to tell you about treatment alternatives or to tell you about other health related benefits and services available to you;
- to let health oversight agencies make sure we are following the rules of programs like Medicare or Medicaid;
- to give you marketing materials; a gift that has very little value; or when we tell you about our products or services for your care or treatment.

We may share information with collaborating mental health agencies that are affiliated with the Oakland County Mental Health Authority. As part of your care/wellness team, behavioral health specialists may assist when appropriate in the:

- assessment, diagnosis, and treatment of behavioral health needs when they arise; and
- for compiling and maintaining a comprehensive list of all prescribed medications.

We share information for public health activities. For example, we may disclose information about you to:

- prevent or control disease, injury, or disability;
- report births and deaths, child abuse or neglect, domestic violence, and reactions to medications or problems with products;
- notify people of recalls of products they may be using;
- notify a person who may have been exposed to a disease or may be at risk for contacting a disease or condition.

We share information for legal reasons.

- When we must respond to a legal order or other lawful process. This includes sharing information about you if state and federal law requires it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law. If there are subpoenas, discovery request or other lawful process by someone else involved in a dispute, we will release information only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- When we are required to by law to tell the police or other law enforcers, or when we are required by a grand jury or subpoena to:
  - report certain injuries, as required by law – gunshot wounds, burns, injuries to perpetrators of crime;
  - help identify or locate a suspect, fugitive, material witness, or missing person;
  - report about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

- report about a death we believe may be the result of criminal conduct;
- report about criminal conduct at our facility; and
- in emergency circumstances report a crime.

We also use and share information with:
- donor programs, if you are donating or in need of an organ, eyes or tissues;
- medical examiners or coroners to help identify a body or find the cause of death; or
- funeral directors to help them carry out their duties.

We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you receive. These research projects must go through a special process that protects the confidentiality of your medical information. All projects are evaluated to assure that they will be of direct or indirect benefit to our patients and /or community and must be approved by the Honor Community Health's Board of Directors. We may disclose health information about you to people preparing to conduct a research project; for example to help them look for patients with specific health needs.

We may also use and share information about you:
- to prevent or lessen a serious threat to you or others;
- if you are in the military, as required by military rules;
- if you are an inmate, to the correctional institution or law enforcement officials for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution;
- to report findings from an examination ordered by the court; or
- to follow the laws for national safety reasons.

We use and share information as required by other laws not mentioned above; Information that we may use or share only if you give us written permission.

For any purpose not mentioned above. For example, before we can send information to your life insurance company.

To use or share any Highly Confidential Information. We follow federal and state laws that require special privacy protections when we use or share this type of information. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, we are required to get your permission before disclosing that information to others in many circumstances.

B. Your Rights Regarding Health Information About You

You have the right to look at your own medical information and to get a copy of that information (the law requires us to keep the original record). This includes medical and billing records. You must sign a request form that you can get form the Medical Records Department. If you want copies, we will charge a reasonable cost-based fee for them; the information will usually be provided within 30 days. You can look at your records at no cost. In some cases, we may not let you see or copy your record. If that happens, we will tell you why and explain to you your right to have the denial reviewed. You have the right to access protected health information in an electronic format if we maintain protected health information in such format.

You can ask us to make changes to your medical record if you think that what we have is wrong or not complete. You must put your request writing and give a reason why you want to make the changes. We will make the changes unless we believe that the information you want changed is complete and accurate, or if the information was not created by us. If we deny your request, we will provide an explanation within 60 days.

You can ask for a list of anyone we shared information with and when we shared it, except for information disclosed for treatment, payment or health care operations or for those disclosures you specifically authorized. You have to ask for this in writing. Your request must tell us a specific time period (beginning after January 16, 2012) of not more than six years. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year.

You can ask us, in writing, to limit who gets information about you. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request and may deny if it would affect your care. If we do agree, we will follow your request unless there is an emergency reason we need to share this information. If you pay for a service or health care item out-of-pocket in full, you can ask us, in writing, not to share that information for the purposes of payment or out operations with your health insurer. We will comply unless that law requires us to share the information.

You have the right to ask us, in writing, to send information to you at a different address or contact you in a different way. For example, you may ask us to send information to your work address or a post office box instead of your home address. You do not need to tell us the reason for this.

We will comply with all reasonable requests.

If you signed an authorization, you can withdraw the authorization. You must sign a form to do this. We cannot do anything about information that we already shared, but we will not share any more after you give us the signed form.

You can ask for a paper copy of this Notice at anytime.

You have a right to complain if you believe your privacy rights have been violated. You may file a complaint, in writing, with us or with the Secretary of the Department of Health and Human Services. Making a complaint will not change how we treat you; we will not retaliate against you for filing a complaint.

You have choices about what we share. If you have a clear preference for how we share your information in the following instances, inform us in writing.

- Share information with family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information is a directory
- Contact you for fundraising efforts.

We will never share your information unless you give us permission for marketing, sales of your information, and most sharing of psychotherapy notes.

You have the right to be notified in the event of a breach of your unsecured PHI in the event one occurs, which such notification will be made directly to you or by alternative means as permitted by applicable law and regulations.

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but, if we do agree, we will abide by our written agreement signed by you and us (except in an emergency). We are required to agree to a request for restriction if it relates to a disclosure to a health plan for purposes of carrying out payment or health care operations and the PHI pertains solely to a healthcare item or service for which we have been paid by you out-of-pocket in full.

C. Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

D. Applicability, Changes to this notice, Contact Information, and Effective Date

This Notice applies to all of your medical information maintained by Honor Community Health, whether it is information we created or that we received from somewhere else. We reserve the right to change the terms of the Notice. Your privacy rights may change if the laws change. When that happens, we will change the Notice and post it where you will be able to read it. The new Notice will be used for all the information that we have about you. We must follow the terms of the Notice that is currently in effect. You can also get a copy of the new Notice, or, if you have any questions about this Notice, please ask the medical receptionist. The effective date of this Notice is January 16, 2012.