APPLEGATE VALLEY FAMILY MEDICINE

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )
Cell phone no.: ( )	Email Address**:	Driver's License no.:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Preferred Pharmacy:
Other family members seen here:

Please be advised that we do not have secure email and cannot answer medical questions this way

(The follow questions are voluntary and used solely for Meaningful Use purposes).

Race:	❑ Declined	❑ American Indian/ Alaska Native ❑ Nat Hawaiian/ Pacific Islander	❑ Asian ❑ Other	❑ Black/ African American ❑ White
Religion:	❑ Declined	❑ Buddhist ❑ Catholic ❑ Jewish ❑ N/A	❑ Hindu ❑ Other	❑ Islam ❑ Protestant
Ethnicity:	❑ Declined	❑ Hispanic or Latino	❑ Not Hispanic or Latino	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is your condition related to on the job accident? (Current or previous) ❑ Yes ❑ No

Is your condition related to a motor vehicle accident? ❑ Yes ❑ No

Is your condition related to any other accident? ❑ Yes ❑ No

Do you have medical insurance? ❑ Yes ❑ No

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ AllCare	❑ Regence BC/BS	❑ HealthNet	❑ Pacific Source
❑ Aetna	❑ United Healthcare	❑ CareSource	❑ Welfare *(Please provide coupon)*	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Street Address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Applegate Valley Family Medicine, MidRogue IPA (billing department) or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

APPLEGATE VALLEY FAMILY MEDICINE

NEW PATIENT MEDICAL REVIEW

NAME________________________________ AGE ________ DATE OF BIRTH ___________________________

What is the main reason you have made this appointment? ____

Marital status (circle one) single married separate divorce widowed partnered child

Name of spouse/partner/parent ______________________________ Spouse/partner's occupation _______________________

Who is at home with you? ____

Any significant changes in household (divorce, childbirth, etc.)? ____________________________________

What is/was your work? ____

Last grade of schooling completed: ____

What recreational interests do you have? ____

(If needed, please attach an additional page to complete the following questions)

MEDICATIONS

List your medications and the dose you take

Name	Pill strength	How often taken	When first begun

DRUG ALLERGIES: Which medications can't you take? Reaction:

____ ____

____ ____

____ ____

PAST MEDICAL HISTORY

If you have had any of these medical problems, please circle them and write in the date you were first told you had that problem.

Diabetes	Heart attack	Hepatitis	Cancer (type)
High blood pressure	Angina (chest pains)	AIDS	COPD/emphysema
Rheumatic fever	High cholesterol	Asthma	Ulcers
Heart murmur	Stroke	Arthritis	Hiatal hernia/reflux

Other medical problems. Please list:____

Operations: List and give approximate dates. ____

Smoking – current use (packs per day) ____________________

Past use (or how many years have you smoked?)______________

What was your average pack(s) per day for this time? __________

Special diet ___________________________________

Birth weight (children) __________________________

Circle: smoking or nonsmoking household

Gestational age (premature/not premature)

Alcohol – current use __________________________________ Average use in the past ________________________

Recreational drugs – current use__________________________ Past use:__________________________________ Current weight ___________ Maximum weight ____________________ Weight changes over past year______________________

FAMILY MEDICAL HISTORY:	if living		if deceased	
	age	health	age at death	cause of death
Father:				
Mother:				
Brothers or sisters:				

Number of children (or siblings) and their ages:____________________

Health problems of children? ____________________

Has any blood relative had any of the following problems? (**circle**)

diabetes   high blood pressure   heart attack   colon cancer   breast cancer   other cancer
sudden death   other heart disease   mental illness

Please CIRCLE any of the conditions you have had OR currently have as a chronic problem:

GENERAL:
unusual fatigue or weakness
chills, fever
bleeding tendency

EYES:
vision loss
blind areas
seeing double

EARS:
hearing loss
ear infections
vertigo/dizziness

THROAT AND MOUTH:
sore mouth, tongue, lips
hoarseness

HEART:
irregular or skipped beats
racing or fluttering
pounding heart   phlebitis
chest pain
swollen feet, ankles, hands
murmur

NERVOUS SYSTEM:
dizziness
blackout spells
little strokes (TIA's)
numbness or tingling
paralysis
seizures

BONES, JOINTS, MUSCLES:
painful or stiff joints
back pain
cramps in muscles of legs
varicose veins

SKIN:
skin cancer   itching
hair loss   rash

BREAST:
lump or discharge

LUNGS:
persistent cough
coughing up blood, pus, mucus
shortness of breath
wheeze
sit up to breathe

STOMACH AND INTESTINES:
difficulty swallowing   jaundice (yellow skin)
frequent indigestion or heartburn   pancreatitis
nausea/vomiting   gallbladder disease
diarrhea/constipation
black stools
abdominal pain/stomachache

GENITO-URINARY:
pain or burning on urination   kidney stones
night frequency (excessive)   impotence
slow starting or stopping   loss of libido (sex drive)
discharge, bloody or dark urine   syphilis, gonorrhea or Chlamydia

MOODS/PSYCHIATRIC:
lack of memory   alcoholism
depression   drug dependence, addiction
anxiety
nervous breakdown
extreme mood swings/bipolar disorder
other mental condition

MENSTRUAL/GYNECOLOGICAL:
bleeding after intercourse
abnormal vaginal bleeding   date of last period:_________
abnormal Pap smear   date of last PAP:___________
hot flashes/night sweats   date of last Mammo:

ABUSE: (Are you unsafe in any way?)
physical   verbal
emotional   sexual

SIGNATURE________________________ DATE COMPLETED ________________________

APPLEGATE VALLEY FAMILY MEDICINE, LLC.

FINANCIAL POLICY

Payment is required at the time services are rendered. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. We accept cash, personal check, MasterCard, Visa, Discover and Debit cards. There is a service charge of $35.00 for any returned checks in addition to all bank fees.

Patients with a balance over 60 days old will be charged a monthly billing fee of $10.00. Account balances that are 90 days or more without payment will be turned over to a collection agency. The patient may then be suspended or discharged from care.

PATIENTS WITHOUT INSURANCE:

Our policy is to collect $150.00 at the first visit. Payment arrangements can then be made for any additional amount if requested. Payments for any future visits will be expected at the time of service.

INSURANCE:

We will bill your insurance companies as a courtesy to you. Due to the numerous health plans, it is your responsibility to know what your particular plan covers for your healthcare. You will need to keep us informed of any changes to your insurance coverage.

If you are insured by a health plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. Charges billed to non-contracted plans are often reimbursed at a lower rate resulting in a higher out of pocket expense for the patient. With some plans, charges may not be reimbursed at all. If the insurer sends the payment directly to you, it is your responsibility to reimburse this office for your account.

For services that are not covered by your insurance company, you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office.

PERSONAL INJURY/MVA

If your medical need is the result of a personal injury or motor vehicle accident, we will bill your carrier for you. Please provide us with all of the necessary billing information and claim numbers. We will ask you to sign a Disclaimer form.

WORKER'S COMPENSATION

We do not take OUT OF STATE Worker's Compensation cases or new worker's compensation cases that are in litigation. For worker's compensation claims, we will need the date of injury, claim number, adjuster's name, name of employer, copy of the completed 801 form and the worker's compensation carrier. We will ask you to sign a disclaimer form.

FORMS

There is a $15.00 charge for the provider to complete any forms for you unless you have an appointment specific to the reason the form needs to be filled out.

NO SHOW FEES

Along with our No-Show policy, we will charge a $25.00 fee for scheduled appointments that you do not cancel 24 hours in advance.

If you have any questions or concerns, please ask a staff member.

I have read and understand Applegate Valley Family Medicine's Financial Policy. I agree to pay the established charges for all services rendered to me. I understand that payment is expected at time of service. I also agree that if it becomes necessary to forward my account to a collection agency or to take legal action, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency and/or legal fees for the cost of collections.

I agree to assign insurance benefits to Applegate Valley Family Medicine, LLC, whenever necessary.

____
Printed name of Patient

____ ______________
Signature of Patient or Patient Representative Date

Distribution:
(1) Copy for patient record
(1) Copy for patient or representative

ACKNOWLEDGMENT AND CONSENT

I understand that Applegate Valley Family Medicine, LLC (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

__________________________________ _______________
Patient Signature Date

__________________________________ _______________
Patient Representative Date

Description of Representative's Authority___________________________

APPLEGATE VALLEY FAMILY MEDICINE, LLC

MISSED APPOINTMENT/ LATE CANCELLATION POLICY

Broken appointments and late cancellations represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. When you schedule an appointment with us, we make every effort to arrange a time and date that is convenient for you. To help you remember, we always try to call and confirm your appointment two days prior to your appointment.

It is your responsibility to remember and keep your scheduled appointment. **If you need to cancel or reschedule your appointment, we request that you notify us at least 24 hours in advance.** If you are going to be late for your appointment, please call us as early as possible, so we can reschedule if necessary. If you do not call us in advance and are more than ten (10) minutes late, we may consider it a No-Show.

If you fail to keep your scheduled appointment or do not cancel it, we will consider it a No-Show. This will be documented in your medical chart. If you No-Show a second appointment, we will send you a warning letter and may also send a copy to your insurance company. If you No-Show for a third time, we will no longer be able to provide care for you. We will send you a discharge letter giving you thirty (30) days to find another medical provider. During this thirty day period, we will provide only emergency care for you.

We reserve the right to charge a $25.00 fee to you for any missed or late-canceled appointments.

Thank you for helping us be available to care for your health needs.

I have read and understand this appointment policy.

__________________________________ ____________________

Patient or Patient Representative Date

Premission to Disclose Health Information

We may disclose your health information to a family member, personal representavie, a friend or to other person(s) to the extent necessary to help with your healthcare, **but only if you agree that we may do so**. Please list the individules below who have your permission to share your health and/ or financial information.

Name	**Relationship to Patient**	**Signature of Patient**	**Date**	**Information OK to Release**
				☐ Medical ☐ Financial ☐ Revoked Initial & Date
				☐ Medical ☐ Financial ☐ Revoked Initial & Date
				☐ Medical ☐ Financial ☐ Revoked Initial & Date
				☐ Medical ☐ Financial ☐ Revoked Initial & Date
				☐ Medical ☐ Financial ☐ Revoked Initial & Date
				☐ Medical ☐ Financial ☐ Revoked Initial & Date

* Caregivers and those with Power of Attorney who are filing out this form should include their names on this list

APPLEGATE VALLEY FAMILY MEDICINE

PRESCRIPTION REFILLS POLICY

DEAL DIRECTLY WITH YOUR PHARMACY

PLEASE DO NOT CALL OUR OFFICE WITH A REFILL REQUEST

Call your pharmacy for refills, even if your prescription indicates "no refills." The pharmacy gathers all of the necessary information and faxes a request to us. When we receive the request, your chart will be reviewed by your provider who will decide what best meets your health care needs. This will take a little time, so please call your pharmacy 2-3 business days before you run out of medication.

ANTIFIPATE YOUR MEDICATION NEEDS

- Review all your medication with your provider at each visit. Make sure you have enough medication to last until your next scheduled appointment.
- Medications prescribed by Emergency rooms and Urgent Care cannot be refilled. Your pharmacist will call your provider's office for a new prescription. You may be asked to come in for an appointment before we fill the prescription.
- For best service, please call your pharmacy early in the day. Don't wait until late in the afternoon.

SPECIAL REFILL REQUESTS

All narcotics, non-narcotic pain relievers, anti-anxiety medications, and mood elevating drugs are regulated by state law. This may require special handling of your prescription refills. Our office will inform you of the procedure for refill requests for these types of medications.

Applegate Valley Family Medicine, LLC 8600 New Hope Road, Grants Pass OR 97527

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.

Roger Fogg FNP
Darlena Pike, FNP
Nancy Yie, FNP

If you have questions about this notice, please contact Melissa Cale, Office Manager 541-862-2836 or mcale@avfm.us

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by physicians/providers you consult with by telephone (when your regular physician/provider from our office is not available) who provide "call coverage" for your physician/provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the way in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed *Consent* to use and disclose health information for the following purposes:

- **For treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor/provider may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor/provider may use your medical history to decide what treatment is best for you. The doctor/provider may also tell another doctor/provider about your condition so that doctor/provider can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.
- **For payment**. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.
- **For health care operations**. We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.
- **Appointment reminders**. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Treatment alternatives**. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment, alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your *Consent* we will not be permitted to use or disclose your information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

- **To avert a serious threat to health or safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required by law**. We will disclose health information about you when required to do so by federal, state or local law.
- **Research**. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and tissue donation**. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation.
- **Military, veterans, national security and intelligence**. If you are or were a member of the armed forces, or a part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public health risks**. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health oversight activities**. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes.

These disclosures may be necessary for certain state and federal agencies 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 health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, medical examiners and funeral directors**. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify deceased person or determine the cause of death.
- **Information not personally identifiable**. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization, **in writing***, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. If we have HIV, or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization and Consent* mentioned above) from you. In order to disclose these types of records for purposes of *treatment, payment or health care operations*, we will have to have both your signed *Consent* and a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to inspect and copy**. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Melissa Cale in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
- **Right to amend**. If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to Melissa Cale. We may deny your request for an amendment 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:
  - we did not create, unless the person or entity that created the information is no longer available to make the amendment
  - is not part of the health information that we keep
  - you would not be permitted to inspect and copy
  - is accurate and complete
- **Right to request restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. ***We are not required to agree to your request***. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE to Melissa Cale.
- **Right to request confidential communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE to Melissa Cale. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how you wish to be contacted.
- **Right to a paper copy of this notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy contact Melissa Cale.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services or with our office. To file a complaint with our office, contact Melissa Cale, Privacy Officer at 541-862-2836. **You will not be penalized for filing a complaint.**