Dear New Patient,

Welcome to Family Physicians! Enclosed is a packet of information, including a brochure that gives a basic overview of our practice. It is our mission to provide quality Evidence-Based health care in a compassionate and confidential atmosphere. It is our hope that we meet and exceed your expectations.

In compliance with federal regulations (HIPPA, Health Information Portability and Accountability Act), we are enclosing our Notice of Privacy Practices. This notice explains how your health care information may be used and how you may obtain access to this information.

Please read the enclosed information and complete the requested forms. You will find an authorization to release records to our practice. Please complete this form and forward to your previous physician as soon as possible, so that your new physician will have an opportunity to review these records prior to your appointment.

If you have any questions regarding the enclosed information or your upcoming appointment, please feel free to call our office at 330-494-7099. Our staff will be happy to assist you. If you have a special request or concern, please feel free to contact us.

Sincerely,

Family Physicians, Inc.

Family Physicians, Inc.
4860 Frank Ave. NW, North Canton, Ohio 44720

PATIENT-CENTERED MEDICAL HOME

What is a "PATIENT-CENTERED MEDICAL HOME"?

A "Patient-Centered Medical Home" (PCMH) is *how* health care is delivered to patients. The medical home team in your doctor's office manages care and services for you—acting as the "hub" of your care. A medical home can lead to higher quality care for patients, and improved care can lead to lower costs for all of us. PCMH puts the patient at the center of the health care system, and provides primary care that is:

- Accessible
- Continuous
- Comprehensive
- Family-Centered
- Coordinated, and
- Compassionate

Why did Family Physicians, Inc. become a PCMH?

Patient-Centered Medical Home (PCMH) is a major part of our continuous effort to improve quality, safety, and efficiency within our organization. By replacing episodes of care with whole person care, we can help coordinate your long-term health. We believe strongly that providing you with health education and helping you understand your health situation can contribute to better outcomes. Being a PCMH does not affect your insurance coverage in any way. We will provide you enhanced care through same-day appointments and extended hours, and help improve interaction and communication with specialists, other care facilities, and the entire health care team.

YOUR RESPONSIBILITIES ARE:

- To ask questions and be active in your care.
- To provide your health history, symptoms, and other important information, including any changes in your health.

- To inform us whenever there is a problem with a medication you are taking.
- To call our office first with your health concerns unless it is an emergency.
- To inform us whenever you utilize any other health system such as the emergency room or a self-referral to a specialist.
- To have a clear understanding about your treatment goals and future health goals.

OUR RESPONSIBILITIES AS A PCMH ARE:

- To listen to your questions and concerns and to explain disease, treatment, and results in an easy-to-understand way.
- To coordinate your overall care, sending you to trusted specialists if needed.
- To provide you with same-day appointments whenever possible.
- To provide instruction on how to access the care you need when the office is not open.
- To provide clear instructions about your treatment goals and future plans for every visit.
- Address your healthcare needs based on the most recent research on medicine and clinical recommendation regardless of type of insurance.

How do you contact your MEDICAL HOME?

You can contact your Medical Home Team to directly arrange an appointment or to discuss your health care needs by calling **330-494-7099**

We are closed on most major holidays and Sundays. Outside of normal clinic hours, for urgent matters you can still call **330-494-7099** and our call service will call you back.

It will be necessary for you (or someone else involved in your care) to let the Medical Home Team know if you have been seen by another provider. This will allow us to continue to coordinate your healthcare needs.

Our “Patient Portal” also allows you to electronically communicate with your health Care team and to receive electronic reminders and messages about your personal conditions.

FAMILY PHYSICIANS, INC.
4860 FRANK AVE NW
NORTH CANTON OH 44720
330-494-7099

NEW PATIENT INFORMATION

NAME _____ DOB ____/____/____ SEX: M F
(Last) (First) (MI)

ADDRESS _____

HOME PHONE _____ CELL _____EMAIL _____

SOCIAL SECURITY_____ RACE _____ ETHNICITY Hispanic or Non-Hispanic

RELIGION _____ LANGUAGE SPOKEN AT HOME _____

EMPLOYER/OCCUPATION: _____WORK PHONE _____

MARITAL STATUS _____ SPOUSE'S NAME _____

IF UNDER 18: FATHER'S NAME _____ EMPLOYER _____

MOTHER'S NAME _____ EMPLOYER _____

EMERGENCY CONTACT PERSON _____
(Name) (Relationship) (Phone)

INSURANCE INFORMATION

#1 PRIMARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID # _____POLICY/GROUP # _____POLICY HOLDER NAME/DOB _____

#2SECONDARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID # _____POLICY/GROUP # _____POLICY HOLDER NAME/DOB _____

IS THIS A WORKMAN'S COMPENSATION (WORKPLACE) INJURY? YES _____ NO _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED FOR PROCESSING AN INSURANCE CLAIM.

SIGNATURE _____ DATE _____

FOR MEDICARE PATIENTS ONLY: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH FINANCING ADMINISTRATION, ITS INTERMEDIARIES OR CARRIER, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

SIGNATURE _____ DATE _____

MEDICAL HISTORY FORM

NAME_____**DOB**_____

FAMILY INFORMATION

PLEASE LIST OTHER FAMILY MEMBERS WHO ARE, OR WILL BE, PATIENTS HERE:

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY

	MOTHER	FATHER	SIBLING	CHILDREN	GRANDPARENT
CANCER (List Type)					
HYPERTENSION					
DIABETES					
HEART DISEASE					
THYROID DISEASE					
MENTAL HEALTH ISSUE					
SUBSTANCE ABUSE					
OTHER					

SOCIAL HISTORY

TOBACCO USE? YES ____ NO ____ IF YES, WHAT TYPE? _____ HOW MUCH/OFTEN? _____

ALCOHOL USE? YES ____ NO____ IF YES, HOW MUCH/HOW OFTEN? _____

YOUR MEDICAL HISTORY

DO YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.

ANEMIA _____ ASTHMA_____ HYPERTENSION _____ DIABETES_____ DEPRESSION/ANXIETY _____

OTHER MENTAL HEALTH ISSUE _____ SUBSTANCE ABUSE _____ THYROID DISEASE_____ HIGH CHOLESTEROL_____

CANCER (TYPE) _____ HEART DISEASE _____

OTHER CONDITIONS_____

LIST ANY SPECIALISTS YOU SEE AND WHY

PHYSICIAN NAME/OFFICE	REASON

 NAME_____**DOB**_____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION_____

_____

LIST MEDICATIONS / SUPPLEMENTS YOU ARE TAKING

NAME OF MEDICATION	STRENGTH	INSTRUCTIONS
EXAMPLE: Diovan	320mg	½ tablet everyday

LIST ANY SURGERIES/HOSPITALIZATIONS/ACCIDENTS

SURGERIES/HOSPITALIZATIONS/ACCIDENTS	DATE
EXAMPLE: Tonsillectomy	1/2000

SIGNATURE _____ DATE _____

(**FOR OFFICE USE ONLY)**

FAMILY DYNAMICS

FAMILY PHYSICIANS, INC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

With my consent, Family Physicians, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family Physicians, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Physicians, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Physicians, Inc.'s Privacy Officer at 4860 Frank Ave. NW, North Canton, OH, 44720.

With my consent, Family Physicians, Inc. 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.

With my consent, Family Physicians, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as lab results, reminders of care, and patient statements as long as they are addressed to me.

With my consent, Family Physicians, Inc. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, lab results, and patient statements.

I have the right to request restriction from Family Physicians, Inc. on how it uses or discloses my PHI to carry out TPO. However, the practice 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 Family Physicians, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Family Physicians, Inc. may decline to provide treatment to me.

_____ _____

Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

_____

Date

Adopted 2/21/12

Updated 6/1/12

Family Physicians, Inc.
4860 Frank Ave. NW
North Canton, Ohio 44720
PH: 330-494-7099 FAX: 330-494-2147

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENTS NAME_____DATE OF BIRTH_____

FROM: _____
ADDRESS: _____
_____
PHONE: _____

TO: Family Physicians, Inc.
4860 Frank Ave. NW
North Canton, OH 44720
PH: 330-494-7099 FAX: 330-494-2147

For the following reason(s): _____

Designate instructions by checking one of the following: **(IF OVER 25 PAGES, PLEASE MAIL RECORDS)**

_____ One year of office notes, labs, radiology reports

_____ Most recent pap smear/ mammogram/ laboratory results/ colonoscopy/ bone density/ eye exam

_____Entire medical record **including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire medical record **excluding** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Record care from _____ to _____**including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____ Record care from _____ to _____**excluding** information related to the treatment of substance abuse or dependency mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____Other as stated: _____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient has the right to a copy of the confidential healthcare information for which this authorization is being sought
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I authorize records to be released as indicated above. I understand that this release is in effect for one year from date of signature, but I may revoke my consent at any time by providing written revocation to the facility releasing the information.

SIGNATURE:
Patient/Legal Representative: _____ Date: _____

FAMILY PHYSICIANS, INC.
4860 Frank Ave NW
North Canton, OH 44720
330-494-7099

Authorization to Release Information to Family and Friends

Due to federal privacy laws, we are unable to release certain personal health information without your consent. If you wish for information to be released, this form must be completed, signed and returned. In your absence, you must designate personal representative(s) for any personal health information to be released. The written authorization does not mean that we will automatically send information to these individual(s); it simply means that we will release information to them if they request. Such information includes, but is not limited to: individual identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

PATIENT NAME: _____ DOB: _____

Release information to the following representative(s):

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

REASON FOR DISCLOSURE: _____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient understands there is a potential that the information disclosed may be re-disclosed by the recipient and no longer protected by HIPAA regulations
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I hereby authorize Family Physicians, Inc. to provide the above named individual(s) with <u>all</u> medical data, billing, and other information they may request. I understand that this release is in effect for two years following my death or I may revoke my consent at any time by providing written revocation to the facility releasing the information.

Signature of Patient_____ Date_____

Adopted 5/10/12
Revised 3/19/14

Need Care After Hours?
We're here for you!

Illness and injuries that strike after hours don't always have to be treated in the Emergency Room or Urgent Care.

We at Family Physicians welcome after-hours questions and strive to offer you access to care when you need it.

Our team will help you decide where to seek care when you call us first!

- 24-7-365 Family Physicians, Inc. 330-494-7099
- Same day and next-day appointments
- Early morning and evening appointments available

Keep these tips in mind:

- Save time and avoid waiting in the ER or Urgent Care by calling us first when you have questions after hours. We can help you decide when and where to seek care.
- ER visits or Urgent Care visits can end up costing more than an office visit with our office

Family Physicians, Inc.
Financial Policy

In order for our office to deliver the quality of care that you are accustomed to, we have established financial policies.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your co-payment, charges from previous visits, and charges for non-covered services at the time of your visit. We accept cash, checks, and Visa, MasterCard, Discover, AMEX and debit cards.
4. Your account will be charged a fee for returned checks for non-sufficient funds.
5. By Federal Law and Managed Care Contract law, this office is required to collect co-payments at the time of service. If you do not pay your co-payment you will be charged a delinquent co-payment fee.
6. If your insurance denies our charges or does not pay us in a timely manner, you will be responsible for the charges.
7. If your account becomes delinquent we reserve the right to refer your account to a collection agency and report it to a credit bureau. If you are referred to a collection agency you and your family will be dismissed from the practice.
8. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. We will also bill any secondary insurance you may have. If payment is not received from your secondary insurance within 30 days of being submitted, we will bill you for the balance due. If you do not have a secondary insurance, any remaining balance will be your responsibility. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
9. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. If your plan requires you to choose a primary care physician, it is your responsibility to notify your plan. If your plan requires you to have an authorization to see a specialist you will need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will attempt to bill your insurance. Any amount remaining from your out-of-network benefits will be your responsibility to pay.
10. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you are not able to pay in full, you will need to contact our billing department to discuss payment arrangements prior to being seen.
11. MEDICAID PATIENTS: We are contracted with traditional Medicaid and some Medicaid HMO plans. If we are contracted with your plan we will submit your claims. If we are not contracted with your plan we will not submit your claim and you will be considered self-pay and are liable for payment of all services provided. Services may be a covered Medicaid service and other providers may render the service at no cost to you. In the future if you choose to utilize your Medicaid plan you agree to transfer care to a Medicaid provider. Patients that miss an appointment will be discharged from the practice.
12. When an appointment is scheduled with the physician, time is specifically allocated for you. When an appointment is not canceled in advance we consider this a “no show”. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment at least two hours ahead. If two appointments are missed without cancellation, you

will be charged a fee. If three appointments are missed, you and your family will be dismissed from the practice for non-compliance. Any appointment missed on a Saturday will be charged a fee.

13. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions in your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, this becomes your financial obligation.
14. All Saturday appointments, emergent walk-in appointments, and acute appointments scheduled after hours (5:00pm or later) will be subject to an additional fee.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at 330-494-7099.

I have read and have a full understanding of the financial policy of Family Physicians, Inc.

Printed Name: _____ Date of Birth: _____

Signature/Legal Guardian: _____ Date: _____

FAMILY PHYSICIANS, INC.
4860 Frank Ave NW
North Canton, OH 44720
330-494-7099

What is Healthfusion Patient Portal?

HealthFusion is our patient portal service that eliminates time-consuming phone calls and allows you, the patient, on-line access to our office. All requests or questions will be answered within 24 hours. With respect to system security, unlike emails that use multiple servers over the internet, the **Healthfusion** technology allows your provider to use a single server secured by both a firewall and 128-bit encryption to safeguard your privacy. This secured system operates by a password protected log-in that you receive upon registering for the service. Only you will have access to your information. Each family member will receive their own log-in code and password. If the patient is under 18 years of age, the responsible parent will receive the enrollment code and password information.

Benefits of Healthfusion Patient Portal

With **Healthfusion** you can access a wealth of general health information online, view new messages from the practice or take advantage of these many powerful benefits:

- Access and request personal or general information.
- Receive and review Lab Results.
- Request medication refills.
- View and pay your bill on-line.
- Ask non-urgent medical questions.
- Receive documents from your doctor such as immunization records, return to work/school forms, lab result letters, and visit summaries.
- Receive important notifications such as drug recalls or guidance, tailored to your specific health plan, chronic conditions, and disease management.
- No health information is sent via email. When a message is sent from the doctor's office, you receive an email stating you have a new message from **Family Physicians, Inc.** and are directed to log in to **Healthfusion** to review.

If you are interested, we just need your email address. You will receive an email from **Healthfusion** inviting you to create a secured account.

FAMILY PHYSICIANS, INC

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Priscilla Kulenics, Privacy Officer, Family Physicians, Inc. 4860 Frank Ave NW, North Canton, OH 44720, 330-494-7099

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment, including but not limited to specialists and other medical facilities. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the office to treat a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. As well as, family members involved in the care of the patient and family members who request records for genetic testing.

6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. You may restrict certain disclosures of PHI to a health plan or insurance company, for purposes of payment or health care operations, if you have paid in full for a service. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a paper or electronic copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161.**You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than three (3) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Access Report. You are entitled to receive an access report that indicates who accessed your electronic designated record set. In order to obtain an access report you must submit your request in writing to **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161.** The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

7. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161.**

8. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

9. Breach Notification. Affected patients have the right to be notified following a breach of their unsecured PHI.

10. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. This includes most uses and disclosures of psychotherapy notes, disclosures for marketing purposes, and disclosures that constitute a sale of PHI. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time <u>in writing</u>. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Priscilla Kulenics, Privacy Officer, 330-494-7099 ext161.**

Updated 12/11/2011
Updated 2/21/2012
Updated 10/29/2013
Updated 5/12/2015

Patient Bill of Rights and Responsibilities

Family Physicians, Inc. is committed in our mission to provide quality primary health care, and to be the leader of family practice services in Stark County. In carrying out our medical mission, we will respect the human rights of our patients, and provide care in an atmosphere of compassion and confidentiality.

Our patients have the following rights:

- The right to receive medical care and services from board certified family physicians.
- The rights to compassionate and respectful care and service from our physicians and staff.
- The right to receive clear and understandable information regarding your healthcare.
- The right to have access to evidence-based care, patient/family education and self-management support.
- The right to equal access regardless of source of payment.
- The right to participate in all decisions regarding your care and treatment.
- The right to refuse medical treatment.
- The right to discuss your care or treatment plan with your physician and the right to express any dissatisfaction with care or treatment.
- The right to maintain the confidentiality and privacy of the physician/ patient relationship, and the right to maintain confidentiality of your medical record.

Our patients shall agree to the following responsibilities:

- Keep all medial appointments or call in advance to reschedule or cancel.
- Provide complete medical history and information about care obtained outside the practice.
- Follow instructions and guidelines given by your physician.
- Ask questions if you do not understand the medical treatment prescribed by your physician.
- Provide the office with all necessary insurance and billing information so that your claims may be processed.
- Promptly pay appropriate co-payments and deductibles or payment in full at time of service if not covered by a participating insurance carrier unless prior arrangements are made with our billing office.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements
Nondiscrimination Statement: Discrimination is Against the Law

Family Physicians, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Family Physicians, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Family Physicians, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters
- Written information in other formats (large print, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, contact Amy Hupp

If you believe that Family Physicians, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Amy Hupp, 4860 Frank Ave NW North Canton OH 44720, 330-494-7099 , 330-494-2149, ahupp@familyphysiciansinc.org. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English language, assistance services, free of charge, are available to you. Call 1-330-494-7099

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-330-494-7099

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-330-494-7099

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-330-494-7099

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-330-494-7099

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-330-494-7099

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-330-494-7099

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-330-494-7099

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-330-494-7099

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ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-330-494-7099

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-330-494-7099まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 330-494-7099

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-330-494-7099

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-330-494-7099