

PATIENT INFORMATION

Date _____
Last Name _____ First _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____ Business Phone # _____
Social Security # _____ (not required if payment is made in full today).
Sex _____ Birth Date _____ / _____ / _____
Race _____ Primary Language Spoken _____
Email Address: _____
Employer _____ Occupation _____
Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Name of Referring Physician _____ Name of Primary Care Physician _____
Name of Emergency Contact _____ Phone # _____

How did you hear about us (circle all that apply)?

Family/Friend Referred by Physician Radio TV Internet Yellow Pages Insurance Listing Other _____

If your insurance is in someone's name other than yourself, we need:

Name of Subscriber _____ Relationship _____
Address _____
Home Phone # _____ Business Phone # _____
Social Security # _____ Birth Date _____ / _____ / _____
Employer _____
Occupation _____

Please present your insurance card to receptionist after completing this form.

Digestive Health Specialists, PA

Patient History

Name: _____ Date of Birth: _____ Male Female
 Occupation: _____ Hobbies: _____ Date _____

Please complete both pages of this form. Check off any conditions you may have now, or have experienced in the past.

****Please check None within each section that does not apply to you.****

Allergies:

None Aspirin Demerol Morphine Penicillin Sulfa Valium Versed Other _____

Past or Present Medical Problems:

<input type="checkbox"/> None of these	<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Reflux
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Liver Cancer	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Liver Disease	_____
<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Anemia	<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Colon Polyps	_____

Surgeries/Hospitalizations/Procedures:

<input type="checkbox"/> None of these	<input type="checkbox"/> Heart Valve	<input type="checkbox"/> ERCP	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Prostate
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Gallbladder Surgery	<input type="checkbox"/> Liver Biopsy	<input type="checkbox"/> Upper Endoscopy
<input type="checkbox"/> C-Section	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Obesity Surgery	_____

Social History Marital Status:

Single Separated Married
 Divorced Widowed

Social History Recreational/Street Drugs:

I have never used street drugs I am currently using street drugs
 I have used street drugs in the past I have been treated for substance abuse

Social History Alcohol:

Never More than 2 days per week
 Rarely 2 days per week or less
 Daily I quit using alcohol

Social History Tobacco:

I use tobacco products I have never used tobacco
 I quit using tobacco products

Review of Systems

Stomach and Intestinal:

<input type="checkbox"/> No Problems	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Milk Intolerance	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Soiling	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Irritable Bowel Disease	<input type="checkbox"/> Trouble Swallowing	_____

Reproductive Organs:

<input type="checkbox"/> No Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Frequent Urinary Infections	Male
<input type="checkbox"/> Change in Urinary Frequency	<input type="checkbox"/> Testicle Problems
<input type="checkbox"/> Sexually Transmitted Disease	Female
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Heavy Periods
<input type="checkbox"/> Sexual Difficulty	<input type="checkbox"/> Breast Lumps

Skin:

<input type="checkbox"/> No Skin Problems	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Chronic Rash
<input type="checkbox"/> Nodules	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Overall Itching	<input type="checkbox"/> Other: _____

Heart and Blood Vessels:

<input type="checkbox"/> No Heart problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Angina/Chest Pain with Activity	<input type="checkbox"/> Swelling in the Legs
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Pain in Legs when Walking	

Brain and Nervous System:

<input type="checkbox"/> No Problems	<input type="checkbox"/> Weakness in Arms
<input type="checkbox"/> Chronic Numbness/ Tingling	<input type="checkbox"/> Weakness in Legs
<input type="checkbox"/> Seizures	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Stroke or Paralysis	

Name: _____

Hormone and Glands:

- No Problems
- Diabetes Taking Insulin
- Diabetes Taking Oral Medication
- Thyroid
- Other: _____

Body Health

- No Problems
- Fatigue
- Fever
- Night Sweats
- Poor Appetite
- Weight Gain
- Weight Loss
- Weight Stable
- Other: _____

Mental Health:

- No Mental Health Problems
- Abnormal Sleep
- Bipolar Disorder
- Chronic Anxiety
- Depression
- Memory Loss/Confusion
- Other: _____

Eyes:

- No Eye Problems
- Cataracts
- Change in Vision
- Glasses / Contacts
- Glaucoma
- Other: _____

Blood and Tissue:

- No Problems
- Bleeding Doesn't Stop Easily
- Enlarged Glands
- Frequent Bruising
- Other: _____

Ears, Nose and Throat:

- No Problems
- Bleeding Gums
- Chronic Sinus
- Hearing Loss
- Hoarseness
- Mouth Sores
- Nose Bleeds
- Ringing in Ear
- Other: _____

Bones, Muscles and Joints:

- No Bone or Joint Problems
- Back Pain
- Disc Problem
- Sciatica
- Swollen Joints
- Other: _____

Breathing:

- No Breathing Problems
- Chronic Cough
- Cough up Blood
- TB
- Positive TB Test
- Other: _____

Family History:

- No Family History of Colon Cancer
- No Family History of Polyps
- Adopted (Don't Know Family History)

Family History: Please place a check mark by all that apply

	Father	Mother	Brother	Sister	Grandfather	Grandmother
Deceased						
Healthy						
Alcoholism						
Colitis (Colon Inflammation)						
Colon Cancer						
Age at Diagnosis						
Colon Polyps						
Crohn's Disease						
Liver Disease						
Stomach Cancer						
Tendency of Bleeding						
Ulcer Disease						
Other Disease (write in)						

Current Medications: Please list all prescriptions and over the counter medications you are currently taking.

Name	Strength	Frequency	Name	Strength	Frequency

Continue on back if needed

Digestive Health Specialists, P.A.

FINANCIAL INFORMATION

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. If we must bill you for any of these items a \$5.00 billing fee will be added to your account. A \$5.00 billing fee will also be charged to your account for each statement we send you with unpaid balances over 45 days old. Payments may be made with cash, check, or credit card. Returned checks will be subject to a \$20.00 fee. Please let us know if you are having a particular financial problem, we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our Billing Supervisor.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. If you provide us with your correct insurance policy information and any needed referral forms, we will file, as a courtesy to you, up to two separate insurance claim forms free of charge for each service you receive. A \$15.00 fee will be charged for each additional claim form you ask us to submit on your behalf. Even though we may submit insurance claims for you, your insurance coverage is a **contract between you and your insurer** and you are still responsible for payment of services regardless of the amount your insurance pays.

Additional Fees:

Missed Appointments: Please understand that when you reserve an appointment with one of our physicians we are making a commitment to your medical care and this prevents another patient from receiving care at that time, to assist all of our patients with appropriate access to our physicians we may charge a \$25.00 fee for any office visit appointment canceled with less than 24 hours notice and a \$75.00 fee for any procedure appointment canceled with less than 72 hours notice.

Medical Forms: The completion of disability forms, attending physician statements, and other supplemental insurance forms all require physician and staff time to complete, accordingly a \$20.00 fee will be charged to complete most of these forms. Non-standard forms may be higher.

Collection Agencies: If it becomes necessary to place this account with a third party for collection due to non-payment, the person responsible for payment will be charged an additional fee over and above the unpaid portion to cover collection fees. Your signature on this page constitutes an agreement to this policy.

Nurse Visit: Please note that if a patient comes in without an appointment to speak to a nurse, there will be a charge for that visit.

I have read and agree to the above policies and authorize payment directly to Digestive Health Specialists, P.A. for any surgical or medical benefits, if any, otherwise payable to me for all services rendered.

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT _____ **DATED** _____

Digestive Health Specialists, P.A.

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Digestive Health Specialists, P.A.** (DHS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DHS. I understand that any diagnosis or treatment of me by my attending physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. DHS is not required to agree to the restrictions that I may request. However, if DHS agrees to a restriction that I request, the restriction is binding on DHS and my attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that my attending physician or DHS has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Notice of Privacy Practices

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Digestive Health Specialists, P.A.** (DHS). The Notice of Privacy Practices also describes my rights and the duties of my attending physician with respect to my protected health information.

An individual copy of the DHS Notice of Privacy Practices is available to anyone that requests a copy. DHS has also posted the Notice of Privacy Practices in each DHS reception room and on the DHS web site at www.digestivehealth.ws.

Digestive Health Specialists, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If the notice is changed, I may obtain a revised notice of privacy practices by accessing the **Digestive Health Specialists, P.A.**'s web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The DHS's Notice of Privacy Practice has been provided to me and I have been provided the opportunity to review the notice prior to signing this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES OF

Digestive Health Specialists, P.A.

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.

A. WE MUST PROTECT HEALTH INFORMATION ABOUT YOU.

We are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

We must protect PHI that we have created or received about: your past, present, or future health condition; health care we provide to you; or payment for your health care.

We must notify you about how we protect PHI about you.

We must explain how, when and why we use and/or disclose PHI about you.

We may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures which occur as a byproduct of the permitted uses and disclosures described in this Notice

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

Posting the revised notice in our offices; making copies of the revised notice available upon request (either at our offices or through the contact person listed in this Notice); and posting the revised notice on our website www.digestivehealth.ws

B. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR PERMISSION IN THE FOLLOWING CIRCUMSTANCES.

1. We may use and disclose PHI about you to provide health care treatment to you.

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

EXAMPLE Your doctor may share medical information about you with another health care

provider. For example, if you are referred to another doctor, that doctor will need to know if you are allergic to any medications. Similarly, your doctor may share PHI about you with a pharmacy when calling in a prescription or with a laboratory when ordering lab tests.

2. We may use and disclose PHI about you to obtain payment for services.

Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of medical information about you with the following:

- Billing departments;
- Collection departments or agencies, or attorneys assisting us with collections;
- Insurance companies, health plans and their agents which provide you coverage;
- Hospital departments that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and
- Consumer reporting agencies (e.g. credit bureaus).

EXAMPLE: Let's say you have been referred to us for a colonoscopy. We may need to give your health plan(s) information about your condition, for any required pre-authorization, to the hospital where the colonoscopy will be performed and to pathologists, radiologists or other medical professionals that may need to bill you for services they may provide as a result of your colonoscopy. This information is given to our billing department and your health plan so we can be paid or you can be reimbursed. We may also send the same information to any hospital department which reviews our care of your illness or injury.

3. We may use and disclose PHI about you for health care operations.

We may use and disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. We may also disclose PHI for the "health care operations" of any "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the care provided by a hospital and the physicians who see patients at the hospital. In addition, we may disclose PHI about you for the "health care operations" of other providers involved in your care to improve the quality, efficiency and costs of their care or to evaluate and improve the performance of their providers. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients. For example, we may use PHI about you to develop ways to assist our health care providers and staff in deciding what medical treatment should be provided to others.

Improving health care and lowering costs for groups of people who have similar health problems and to help manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives, classes, or new procedures.

Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.

Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.

Cooperating with outside organizations that assess the quality of the care we and others provide. These organizations might include government agencies or accrediting bodies.

Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.

Assisting various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with applicable laws.

Conducting business management and general administrative activities related to our organization and the services it provides.

Resolving grievances within our organization.

Reviewing activities and using or disclosing PHI in the event that we sell our business, property or give control of our business or property to someone else.

Complying with this Notice and with applicable laws.

4. We may use and disclose PHI in other situations without your permission.

We may use and/or disclose PHI about you without your permission in situations when the use and/or disclosure:

- is required by law.*
- is necessary for public health activities.*
- relates to victims of abuse, neglect or domestic violence.*
- is for health oversight activities.*
- is for judicial and administrative proceedings.*
- is for police or other law enforcement purposes.*
- relates to a person who has died..*
- relates to organ, eye or tissue donation purposes.*
- relates to medical research in certain limited situations.*
- is to prevent a serious threat to health or safety.*
- relates to specialized government functions.*
- relates to inmates of correctional institutions and in other law enforcement custodial situations.*

5. You can object to certain uses and disclosures.

Unless you tell us not to, we may use or disclose PHI about you in the following circumstances:

We may share your name and your general condition (critical, serious, etc.) with clergy and with people who ask for you by name.

We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. We also may notify such individuals of your location, general condition or death.

We may share with a public or private agency (for example, American Red Cross) PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary for the emergency circumstances.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please tell the front desk person who registered you or contact our Privacy Official listed on the cover page of this Notice.

6. We may contact you to provide appointment reminders.

We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

7. We may contact you with information about treatment, services, products or health care providers.

We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.

EXAMPLE: If you are diagnosed with celiac disease, we may tell you about nutritional and other counseling services that may be of interest to you.

**** ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION ****

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. We will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

C. YOU HAVE SEVERAL RIGHTS REGARDING YOUR PHI.

1. You have the right to request restrictions on uses and disclosures of PHI about you.

You have the right to request that we restrict the use and disclosure of your PHI. You must ask us in writing. We are not required to agree to your requested restrictions. Even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and

Human Services, and uses and disclosures described in subsection B.4 of the previous section of this Notice. You may request a restriction by filling out a form that you can obtain from our front desk personnel. Your request will be granted unless we tell you otherwise in writing.

2. You have the right to request different ways to communicate with you.

You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number instead contacting you at home. Your request must be in writing. We will accommodate all reasonable requests, if we can. In order for us to do this, you must provide us with information regarding how payment, if any, will be handled. You must also provide us with an alternative address or other method of contact. You may request alternative communication by completing an alternate communication form available from our front desk personnel.

3. You have the right to see and copy PHI about you.

You have the right to inspect and obtain copies of your PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may contact our front desk personnel for request forms.

4. You have the right to request amendment of PHI about you.

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you that you believe are incorrect or incomplete. Your request must be in writing and must explain why you want us to make the change. We do have to make the change if: 1) the information was not created by us (unless the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. You may request an amendment of PHI by completing the Medical Record Amendment/Correction form available from our front desk personnel.

5. You have the right to a listing of non-routine disclosures we have made.

You have the right to request an "accounting of disclosures." This is a list of the non-routine disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. You must submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of

disclosures by completing a disclosures request form available from our front desk personnel.

6. You have the right to a copy of this Notice.

You have the right to request a paper copy of this Notice at any time. You may contact any of our front desk personnel or Peter S. Donaldson, Privacy Official for Digestive Health Specialists, 2025 Frontis Plaza Blvd, Suite 200, Winston-Salem, NC 27103, 336-768-6211. In addition, this notice is posted on our web site www.digestivehealth.ws and in our office. We will provide you with a copy of this notice for you to review when you arrive for your first office visit.

D. YOU MAY HAVE ADDITIONAL RIGHTS UNDER OTHER LAWS.

Some North Carolina laws give greater protection of privacy than federal laws. We must follow both federal and state law. These North Carolina laws may apply to our treatment of you:

North Carolina law protects not only your rights of privacy, but also your relationship with your physician. State law generally restricts disclosure of your health information in most instances. However, we may disclose health information about you under State law with your permission, pursuant to a court order, or as otherwise may be permitted or required by law. In instances in which your permission is required, we will request that you sign a consent form (which is different than an authorization that is mentioned in other parts of this Notice).

If you ask for treatment and rehabilitation for drug abuse, your request will be confidential. We will not give your name to any police officer or other law-enforcement officer unless you give us permission to do so. If we refer you to another person for help, we will continue to keep your name confidential.

If you have a communicable disease (for example, tuberculosis, hepatitis or HIV/AIDS), information about your disease will be kept confidential, and only will be shared without your written permission in limited situations. For example, we will get your permission to share this information for payment purposes. We do not need to get your permission to report information about your disease to State and local health officials or to prevent the spread of the disease.

E. YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES.

If you think we have violated your privacy rights, or you want to complain to us about our privacy practices, you can contact **Peter S. Donaldson, Privacy Official, 336-768-6211**. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

F. EFFECTIVE DATE OF THIS NOTICE: This Notice of Privacy Practices is effective on April 14, 2003.