TMJ THERAPY AND SLEEP CENTER OF COLORADO
Kevin S. Berry, DDS
Dr. Berry PC

1660 S Albion St #1008
Denver, CO 80222
303-691-0267

PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial _____

Address_____ Do you live here 6+ months/year Y N

City/State_____ Zip Code_____ -_____

Home Phone _____ Date of Birth _____

Work Phone _____ Social Security # _____

Cell Phone _____ Employer _____

Email _____ Sex Male Female

Responsible Party (if other than patient)

Last Name _____ First Name _____ Date of Birth _____

Address_____ Phone _____

City/State/ ZIP__ _____ Employer _____

INSURANCE - Please provide your PPO medical insurance information. In most cases, treatment is for a medical condition. We can bill your dental insurance. This office will file with your primary insurance only. Secondary insurance is your responsibility to file.

Primary Insurance _____ Suscriber ID _____

Billing Address _____ Subscriber Name _____

_____ Subscriber Date of Birth _____

Phone for providers _____ Group # _____

If due to trauma, Date of accident _____ Adjuster Name _____

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FINANCIAL POLICY

Unless prior arrangements have been made, payment for service is due at the time of the service.
We accept Cash, Check, MasterCard, Visa, Discover, CareCredit or Lending Club financing.
This office will *estimate* your out of pocket expense. You will be asked to pay this portion at the time of service.
Any balance that remains after insurance is complete will be due within 30 days unless other arrangements have been made in writing. Insurance balances are ultimately the Patient's obligation.
Some treatment may not be covered by your insurance. This office cannot guarantee insurance payment
Please give 36 hour notice of cancelation.
This office reserves the right to charge for excessive last minute cancellations and no shows.
There will be appropriate additional fees charged for returned checks.
Unpaid patient balances may be sent to an outside agency for collection.
We have "OPTED OUT" of Medicare/Medicaid and enter into private contracts with Patients. Please notify the staff if you participate in these programs as they will not process claims or cover any services provided by our office.

X_____ _____
Signature Date

ASSIGNMENT/ RELEASE/ CONSENT

I certify that I (or my dependent) have insurance coverage with the above named company. I understand that, unless prior arrangements have been made, payment of insurance benefits on the claim form will be directed to the doctor/ doctor office. I hereby authorize the doctor to release all information necessary to secure payment of benefits and I authorize the use of this signature on all insurance submissions. Dr. Berry PC cannot bill your insurance without the appropriate signature below.

I herby warrant that I have not been legally adjudged as incompetent. I understand that it is my right to determine the extent of my medical/dental care, and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment. I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, test procedure, or therapy performed by Dr. Berry PC physicians and/or staff.

X_____ _____
Signature Date

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ **Date** _____

List any medication currently being taken: (you may bring a pre printed list)

Medication name	Dosages/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medications/substances which have caused an allergic reaction:

_____ _____ _____
_____ _____ _____

Please check any of the following conditions you now have or have had in the past:

Illnesses:

___ Allergies
___ Anemia
___ Arthritis
___ Asthma
___ Cancer
___ Chest Pain
___ Chronic Cough
___ Creutzfeldt- Jakob Dis.
___ Diabetes
___ Ear problems
___ Epilepsy
___ Excessive urination
___ Fainting Spells
___ Glaucoma
___ Heart murmur
___ Heart attack
___ Hepatitis A B or C
___ High blood pressure
___ HIV
___ Kidney disease
___ Liver disease
___ Low blood pressure
___ Neurological Problems
___ Rheumatic fever
___ Sinus problems
___ Sleep Apnea
___ Stroke
___ Thyroid disorder
___ Tonsillitis
___ Tuberculosis
___ Ulcers - gastric
___ _____
___ _____

Past Injuries:

___ Arm
___ Back
___ Broken Bone
___ Excessive Bruising
___ Leg
___ Falls
___ Sprains
___ Head or neck
___ Concussion
___ Other _____
___ Other _____
___ No Injuries to report

Hospitalizations/Surgeries and dates:

_____ _____ _____
_____ _____ _____

Past or Current Treatments:

___ Chemotherapy
___ CPAP/APAP
___ Chiropractic
___ Chiropractic
___ Physical Thearpy
___ Dental Orthotic
___ Cranial Sacral
___ Accupuncture
___ Massage Therapy
___ Other _____
___ Other _____
___ None to report

Family History:

___ Cancer ___ High Blood Pressure ___ Father/Mother snores
___ Depression ___ Thyroid problems ___ Father/Mother Sleep Apnea
___ Diabetes ___ Obesity ___ Family History unkn
___ Heart Disease Other _____

Social History:

For Women: Are you pregnant? YES NO Peri or Post Menopausal? YES NO

Do you smoke or chew tobacco? If yes, how much/week _____ YES NO
Do you drink alcohol? If yes, how much/week _____ YES NO

Current Symptoms:

What is your **chief** complaint?_____

_____

When did this begin? _____

Was this the result of an accident, fall or blow of any kind? YES NO

Please explain_____

Please list all automobile accidents you have been involved in. Give dates, and a description of each occurrence. Indicate if you were the driver or passenger, if you wore a seatbelt or if you hit your head.

Date Driver or passenger Seat Belt Description

_____

_____

_____

_____

Have you ever received a blow to the face/head in any other type of accident or assault? If yes please describe.

Date Description YES NO

_____

_____

Do you have problems with headaches? If yes, since when _____ YES NO

What is their intensity? Mild Moderate Severe

How frequent are they? Constant_____

Daily ____ # of times per day_____

Weekly _____# of times per week_____

Monthly _____# of times per month

If there is a particular time of day/night that your headaches seem to occur or are intense, please describe.

_____

Please describe any and all areas of your head where your headaches occur (i.e. top, temples, forehead, etc)

_____

Do you have neck pain? YES NO

Do you have shoulder pain? ____Right ____Left YES NO

Do you have any back pain? ____Upper ____Mid ____Low YES NO

Do you have ear pain? ___Right ____Left YES NO

Do you have any ear congestion or plugged ears? ____Right ____ Left YES NO

Do you have ringing or buzzing noises in your ears? ____Right ____Left YES NO

If yes, are the noises: ____Constant ____ Intermittent

Do you have a problem with dizziness? YES NO

Do you find it difficult to swallow food or liquid? YES NO

Do you have a problem with tooth pain, broken teeth or extreme sensitivity to hot/ or cold? YES NO

If yes please describe the problem and location of the teeth affected.

_____

Do you only chew on one side? ____Right ___ Left YES NO

Do you have a habit of clenching your teeth during the day? YES NO

If yes, how long have you noticed this?_____

Do you clench or grind your teeth at night? YES NO

If yes, how long have you noticed this?_____

Do you ever awaken with a tired or sore jaw? YES NO

Do you have trouble falling asleep? YES NO

Do you have trouble staying asleep? YES NO

Do you snore or wake up gasping for breath? YES NO

Do you feel constantly and or/ easily fatigued throughout the day? YES NO

Have you been diagnosed with sleep apnea? YES NO

Do you have numbness or tingling sensations on the face? YES NO

Do you have any numbness or tingling anywhere else? YES NO

If yes, where? _____ ___

Do you have facial pain? ____Right ____Left YES NO

Do you have pain in your jaw joint (TMJ)? ____Right ____Left YES NO

How long have you had this pain?_____

Do you have popping or clicking sounds in your jaw joint? ____Right ____Left YES NO

How long have you noticed these sounds? _____

Do you have grinding/gravel-like sounds in your jaw joint? ___Right ____ Left YES NO

How long have you noticed these sounds?_____

Have you ever had any TMJ treatment? If yes, when _____ YES NO

-name of treating doctor: _____

Have you ever worn a mouth appliance prescribed by a doctor? YES NO

- name of prescribing dentist _____

-Do you still wear it? YES NO Date received_____

-Was it : Length of treatment_____

____ Lower Frequency of wear_____

____ Upper _____

Do you have any pain when doing any of the following?

___Eating ____Speaking ____Opening Wide

Can you open your mouth wide? YES NO

If no, when could you open wider? _____

Has your jaw ever been locked? YES NO Open Closed When _____

Does your bite feel "off"? If yes, since when? _____ YES NO

Review of Systems: Please circle any that currently apply. Feel free to add to the list provided.

Constitutional: Fatigue Night sweats Weight gain Weight loss

Eyes: Dry eyes Headaches Vision changes Eye pain Itchy eyes

Ear, Nose Ear pain Ear pressure Tinnitus Hearing loss Nasal/sinus congestion

Mouth, Throat Tooth pain Oral pain Dry mouth Throat pain Difficulty Swallowing

Cardiovascular: Chest pain/pressure Cold hands/feet Palpitations Fainting Hypertension Heart Disease

Respiratory: Pain with breathing Productive cough Chronic cough Wheezing Asthma COPD

Gastrointestinal: Abdominal pain Heartburn Hepatitis Acid reflux

Genitourinary: Blood in urine Discharge Lesions Tenderness Incontinence

Musculoskeletal: Bony fractures Joint pain_____ Joint stiffness_____ Muscle weakness Sprain Muscle pain Arthritis _____

Skin: Dry Skin Knots/Skin nodules Rash Lesions Cancer

Neurological: Dizziness Headaches Gait Disturbance Numbness Speech Disturbance Seziures Tingling Coordination issues Parkinson's Alzheimer's Dementia Concussion Difficulty concentrating or remembering

Psychiatric: Depression Anxiety Nervousness

Lymphatic: Anemia Bleeding Lymph node pain/enlargement Thyroid issues

Additional information_____

_____

_____

_____

SLEEP HISTORY CONSULTATION

COMPLAINTS: (*Please mark all that apply*)

___ CPAP, BiPAP OR APAP difficulty
___ Daytime tiredness
___ Difficulty falling asleep
___ Decrease in concentration
___ Impaired thinking ability
___ Gasping/Choking that wakes you
___ Loud snoring/affecting sleep of others
___ Never feels rested
___ Awakes unrefreshed
___ Sleepiness while driving
___ You have been told you stop breathing in your sleep
___ Not dreaming
___ Frequent arousal from bed
___ Difficulty swallowing
___ Facial pain
___ Headaches/migraines
___ Jaw clicking/noise in jaw
___ Jaw locking/limited opening
___ Jaw pain
___ Ear congestion
___ Ring in the ears

How many times do you get up in the night? _____

SLEEP STUDY HISTORY:

Overnight sleep study performed at a lab? YES NO

Name of Sleep Lab _____ Date _____

Home Sleep Study? YES NO

Provided by _____ Date _____

Physician who ordered test _____

Diagnosis: ___ Mild ___ Moderate ___ Severe

The evaluation showed a

RDI of _____ -or- an AHI of _____

___ I have never had a sleep study

CONSERVATIVE THERAPY ATTEMPTS: (*Even if you have not been diagnosed, how have you tried to help yourself?*)

___ Avoidance of sleeping on back
___ Weight loss program
Which one? _____
___ Smoking cessation
___ UP3 surgery
___ Nasal/snore strips
___ Nasal sprays
___ Oral surgery
___ Prescription sleep aids
___ Other _____
___ Pillar implants
___ Tonsillectomy
___ Positive airway pressure machine (CPAP)
___ Over the counter medications

_____

Patient Signature and Date

PAP INTOLERANCE: (*Complete if you have tried any PAP therapy and have had difficulties. Mark as many as apply*)

___ Mask leaks

___ Inability to get proper fit

How many different masks have you tried? _____

___ Discomfort from headgear

___ Interrupted sleep

___ Noisy/Interrupts sleep of bed partner

___ Restricted movements

___ Does not seem to be effective

___ Latex allergy

___ Claustrophobia

___ Unconscious need to remove while sleeping

___ Other reasons _____

Affidavit for Intolerance or Non-Compliance to CPAP, BiPAP or APAP

I have attempted to use PAP therapy to manage mu sleep related breathing disorder and find it intolerable for the above reasons. Because of my intolerance / inability to use PAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Repositioning Device.

_____

Patient Signature and Date

Kevin Berry, DDS

Obstructive Sleep Apnea Questionnaire

First Name	Middle Initial	Last Name

Weight	Pounds	**Age**	Years	Gender	Male ◯ Female ◯
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year				

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score ☐

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Co-morbidities
+1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
As a passenger in a car for an hour without a break	◯	◯	◯	◯
Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score ☐

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

☐
☐
☐

Signature

Total all 6 boxes from above **Point Total**

If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk) ☐

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_____
Patient name

Acknowledgment of Receipt of Notice of HIPAA Privacy Practices (NOPP)

I have received a copy of (or had the opportunity to read if I so chose) the NOPP with an effective date of June 1 2017. This was provided to you in your new patient paperwork and is posted in the office and available upon request.

X_____
Signature of Patient/ Parent/ Guardian Date

In Case of an Emergency contact : _____
Phone: ( )_____ - _____ Relationship: _____

Referred by:_____
Address: _____
_____
Phone: ( )_____ -_____

Dentist: _____
Address: _____
_____
Phone: ( )_____ -_____

Primary Dr:_____
Address: _____
_____
Phone: ( )_____ -_____

Other: _____
Address: _____
_____
Phone: ( )_____ -_____

Relatives, Close Friends or Other Care Givers/ Attorney _____
Address: _____
_____
Phone: ( )_____ -_____

I give permission to share appointment, billing or medical information with the persons named unless otherwise indicated.

May we leave appointment, billing or medical information on your answering machine/ voice mail/ e-mail? Yes No

Signature X_____ Date _____

TMJ Therapy and Sleep Center of Colorado
Dr. Berry PC
Effective: 1 June 2017

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.

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer, __Joan Kalista_at (303) _691-_0267.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. Any revised Notice of Privacy Practices would be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail. A copy of the current Notice of Privacy Practices will be prominently displayed in our office at all times.

USES AND DISCLOSURES

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we may disclose your protected health information, as necessary, to arrange for sleep studies, a Cone Beam CT, or Oral Appliance Therapy.
- **Payment:** Your protected health information may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we provide for you, determining your eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities.
- **Health Care Operations**: We may use or disclose, as needed, your protected health information to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to an insurer or accreditation agency which performs chart audits. We may use or disclose your protected health information, as necessary, to contact you (by phone or mail) to remind you of a scheduled appointment or procedures.

We will share your protected health information with third party "business associates" that perform various activities for our practice (e.g., a computer consulting company, law firm or other consultants). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

USES AND DISCLOSURES BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing, except to the extent that Dr. Berry PC ("Office") has taken an action in reliance on the use or disclosure indicated in the authorization.

The following uses and disclosures will be made only with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of protected health information;
- Most uses and disclosures of psychotherapy notes (if Office maintains psychotherapy notes);
- Other uses and disclosures not described in this Notice of Privacy Practices.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR PERMISSION OR OPPORTUNITY TO OBJECT

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment.

Information to your family members: Unless prior preference is expressed to Office, a deceased patient's health information may be disclosed to a family or other member or other persons who were involved in the individual's care or payment for health care prior to the individual's death if such protected health information is relevant to person's involvement.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES
THAT MAY BE MADE WITHOUT YOUR CONSENT OR AUTHORIZATION

Required by law: we will use and disclose your protected when we are required to do so by federal, state or local law.

Public Health: we may disclose your protected health information to public health authorities that are authorized by law to collect information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may disclose your protected health information, if directed by the health authority, to a foreign government agency that is collaborating with the public health authority. We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your protected health information to a governmental agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Product Monitoring and Recalls: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, and biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or in connection with post-marketing surveillance, as required by law.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such

disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes included (1) legal processes, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of Office, and (6) medical emergency (not on Office's premises) and it is likely that a crime has occurred.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties. Protected health information does not include health information of a person who has been deceased for more than 50 years.

Organ/Tissue Donation: Your health information may be used or disclosed for cadaver organ, eye or tissue donation purposes.

Criminal Activity: We may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety or a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for authorized military purposes, as required by law.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy regulations.

YOUR RIGHTS

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a medical record
maintained by Koala for as long as we maintain the protected health information. We may charge you our standard fee for the costs of copying, mailing or other supplies we use to fulfill your request.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You also may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

In most circumstances, your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if you request us to restrict disclosures to health plans that we would normally make as part of payment or health care operations, then we must agree to that restriction if all of the following apply: (1) your request for restricted disclosure must relate to our disclosures for payment or healthcare operations purposes; (2) disclosure of the information is not otherwise required by law; and (3) the information restricted pertains solely to a healthcare item or service for which you, or someone on your behalf, has paid in full.

If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in

mind, please discuss any restriction you wish to request with your physician. You may request a restriction using the form for requests for restrictions on protected health information from the Privacy Officer, or you may provide us your request, in writing. Your request must include (a) the information you wish restricted; (b) whether you are requesting to limit the Practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

You have the right to electronic copies of your protected health information when requested. Where information is not readily producible in the form and format requested, the information must be provided in an alternative readable electronic format as agreed to by you and Office may charge a reasonable cost based fee for labor in copying protected health information and postage where you request that information be transmitted via mail or courier.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may ask us to contact you by mail, rather than by phone at home. You do not have to provide us a reason for this request. We will accommodate reasonable requests. We also may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.
You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you that we maintain. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies generally to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. However, you do have the right to an accounting of disclosures for treatment, payment or health care operations if the disclosures were made from an electronic health record.
Your right to an accounting of disclosures excludes disclosures we may have made to you, or to family members or friends involved in your care, or for notification purposes.
You have the right to receive specific information regarding other disclosures that occurred up to six years from the date of your request (three years in the case of disclosures from an electronic health record made for treatment, payment or health care operations). You may request a shorter timeframe. The first list you request within a 12-month period is free of charge, but there is a charge involved with any additional lists within the same 12-month period. We will inform you of any costs involved with additional requests, and you may withdraw your request before you incur any costs.
You have the right to obtain a paper copy of this Notice from us.
You have the right to opt out of fundraising communications (if Office conducts fundraising).
You have the right to receive notice in the event of a breach of unsecured protected health information. This means that you will receive notice if a breach of your protected health information is discovered within 60 days of discovery.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Joan Kalista at 303-691-0267 for further information about the complaint process. **For more information about HIPAA or to file a complaint,** contact the U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201 877-696-6775 (toll-free).