THE MELISSA L. POSNER

Institute for Digestive Health and Liver Disease

AT MERCY

Dr. Mary Harris **Dr. Matilda Hagan**

New Patient Questionnaire

The Institute for Digestive Health & Liver Disease

Mercy Medical Center, Baltimore

301 St Paul Place P.O.B Suite 718, Baltimore, MD 21202

Phone: (410)-332-9356 Fax: (410)783-5884

Drs. Mary Harris & Matilda Hagan

Dear Patient:

Thank you for choosing *The Melissa L. Posner* Institute for Digestive Health and Liver Disease at Mercy Medical Center. Our practice includes Drs. Paul Thuluvath, Michael Cox, Richard Desi, Matilda Hagan, Mary Harris, Scott Huber, Patrick Hyatt, Sergey Kantsevoy, Anurag Maheshwari, Lisa Pichney, Amit Raina, Debra Vachon and Hwan Yoo.

Enclosed you will find the following forms to be completed:

1. Office Policy
2. Patient Demographics
3. Insurance Coverage
4. Current Symptoms
5. Personal/Family/Social History
6. Review of Systems
7. Consents
8. Authorizations and Acknowledgements

Being a new patient, we would like to enter your information in our electronic medical record before your appointment. This can be accomplished by returning these forms to us by fax 410-783-5884, or submitting them in person <u>prior</u> to your visit. ***In addition, you should plan to arrive in our office 30 minutes before your appointment*** *so that this process does not interfere with your time with the physician.*

LATE POLICY:
In an effort to have patients seen on time, a patient who does not arrive **30 minutes prior** to their appointment may be rescheduled at the discretion of the office. If you know you are going to be late, **please call the office at (410)-332-9356.**

CANCELLATION/ MISSED APPOINTMENT POLICY:
Last minute cancellations and no show appointments are very disruptive to the physician's schedule and will, therefore, be charged a $25.00 fee. Please call between the hours of 8:00am – 4:00pm to reschedule your appointment at least 24 hours in advance.

If your insurance requires a referral from your Primary Care Physician to see our specialists, please bring this with you to your appointment or have it faxed to our office **prior to your appointment**. Failure to obtain an insurance referral may result in rescheduling your appointment. **All co-pays and account balances are due at the time of your visit**. We accept cash, check, Visa, MasterCard and Discover. Your appointment may be rescheduled if you are unable to provide payment.

PLEASE BRING THESE ITEMS WITH YOU TO YOUR APPOINTMENT:
1. New Patient Packet if it was not faxed 2. Photo ID 3.Insurance Cards 4. Prescription Card

The Institute for Digestive Health and Liver Disease

ATTENTION ALL PATIENTS

EFFECTIVE May 1st, 2015

In order to maintain organization throughout the office and to guarantee that your needs are met, our office policies are as follows:

- Please call at least **24 HOURS** in advance if you need to cancel or reschedule an appointment. A fee of **$25.00** will be charged to those who do not show for their appointment, or do not give proper notice when cancelling or rescheduling.
- If you do not show up for 3 scheduled appointments within a rolling calendar year, we will request that you seek care with another provider.
- We do require that you have your Insurance cards and photo ID with you at EVERY visit. We ask that you have this ready before you are called to the front desk for check-in.
- If your insurance requires a **REFERRAL** and/or **CO-PAY**, please be prepared to present these at the time of service. If you do not have a referral and/or co-pay at the time of service, you will be asked to reschedule. Please remember, it is the **patient's responsibility** to obtain a referral from your Primary Care Physician.
- If you have a past due balance, our office requires this to be paid at the time of service. If you have not paid at least half of the balance or have not yet made payment arrangements with our billing department we will ask to reschedule your appointment until this has been resolved. Please note we will see you on an emergency basis only.
- Please bring a list of your medications to your appointment, so that we may keep your medical records up to date.
- Please check on any **REFILLS** needed prior to your appointment so we may fill them at your visit.
- If you have any **OFFICE NOTES** from your referring provider; **BLOOD WORK** or **RADIOLOGY** testing performed prior to your visit, and it is pertaining to your visit, please bring these with you, or have them faxed to the office at
  - 410-659-1162- **Dr. Kantsevoy**
  - 410-769-9301- **Dr. Pichney**
  - 410-783-5855- **Dr. Vachon**
  - 410-783-5884- **All Other Physicians**
- If you need to request a refill for a prescription and you are not scheduled to come in for an appointment, please have your pharmacy send an electronic request. Please allow adequate time for refill requests to be processed, we will send a response within **3 business days**.
- Please allow up to **24 HOURS** for calls to be returned for non-urgent problems.
- **We encourage you to use MyChart for all non-urgent messages and appointment requests**
- In the event of an emergency, please dial the **Mercy Hospital Operator** at **410-332-9000** or **911**.

Your cooperation with these guidelines will help our practice provide the best possible care. Thank you for your understanding!

I have read and understand the above guidelines: **PLEASE SIGN**

______________________________ ______________

NAME **DATE**

The Institute for Digestive Health and Liver Disease

New Patient Registration

Last name		First Name		M.I.
Home address		City	State	Zip code
Home phone	Work phone		Cell phone	
Date of Birth	Social Security #		Gender	
E-mail address				

Referring Physician:

Name	Specialty
Office Address	
Office phone number	Office fax number

Primary Physician (if different from Referring Physician):

Name	Specialty
Office Address	
Office phone number	Office fax number

Emergency Contact Information:

Name		Relationship to Patient
Home Phone	Work Phone	Cell Phone

Other Physicians to receive copies:

Name____

Address____

Phone/Fax____

Primary Insurance Information:

Insurance Company Name	Phone Number	Policy Effective Date
Policy Holder's Name	Policy Holder's Employer	
Relationship to Patient	Policy Holder's Date of Birth	Policy Holder's Gender
Policy Holder's Social Security Number	ID #	Group #

Secondary Insurance Information:

Insurance Company Name	Phone Number	Policy Effective Date
Policy Holder's Name	Policy Holder's Employer	
Relationship to Patient	Policy Holder's Date of Birth	Policy Holder's Gender
Policy Holder's Social Security Number	ID #	Group #

Pharmacy Information:

Pharmacy Name	Phone Number	Fax Number
Address		

I certify that the information I have reported above is correct and up to date. I will inform The Institute of Digestive & Liver Disease of changes to this information as they occur.

Patient's Signature ____________________________________Date ______________________

Drs. Mary Harris & Matilda Hagan

New Patient Personal Medical History

Full Name:

____

(First) (M.I) (Last)

Date of Birth: _____________________________ **Reason For Visit**________________

Height: ______ ft. ______ inches **Weight**: _____________lbs.

Education-how many years of school have you completed?____________

Occupation_________________ **Employment Status**_______________

Marital status: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Current Spouse: N/A ALIVE DECEASED/CAUSE________________

____

Immunizations: Influenza / Tetanus / Diphtheria / Pneumonia / Hepatitis B

Do you have any tattoos?________________________

Did you have any blood transfusions? If yes what year?_________________

Have you ever been physically, sexually, or emotionally abused?_____________

Are you Disabled? YES NO **Cause?**___________________

Note: This information becomes part of your medical record and is confidential.

Please list all medical conditions that you have ever had including those that are currently under control (e.g. if you have high blood pressure or diabetes that is controlled with medications, you should still list them here). You do not need to list colds or minor rashes. **Indicate if you have had any of the following:**

Rheumatic Fever_____,Measles_____,Mumps_____,Heart murmur_____,Anemia_____,

Hepatitis_____,Diabetes_____,Heart Attack_____, Lung Disease_____,Kidney Disease_____,

Cancer_____,Stroke_____,Tuberculosis_____,Depression_____

Other Health Problem (example: heart disease, thyroid, diabetes)	**Date or age at time of diagnosis**

Current Medications

Please list all prescription, over-the-counter, and herbal medications that you are **currently** taking (including aspirin, calcium, vitamins, birth control, steroids, body building drugs etc.). If you do not take any medications, write "none".

Medication	**Dose** **(e.g. 25 mg)**	**How often? (e.g. twice per day)**	**Reason for Medication**	**Date started or how many years taking?**

Allergies

Please list all allergies (particularly medication allergies). If you do not have any allergies, write "none".

Allergy or Medication	**Type of reaction (nausea, hives, etc)**

Surgical History

Please list all operations that you have had (e.g. removal of gall bladder, appendix, thyroid, or tonsils).

Type of Surgery	**Date or age at time of operation**

Drs. Mary Harris & Matilda Hagan

Family History

Please list all significant medical problems in family members. It is important for us to know if any of your family members have the same condition for which you are coming to see us. You may omit names. **Please Circle and fill out to the best of your knowledge.*

		If Living		If Deceased	
	Sex	Age	Diagnosis	Age of Death	Cause
Father					
Mother					
Brother/Sisters	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife	M F				
Sons/Daughters	M F				
	M F				
	M F				

Has any blood relative ever had any of the following? If so, state who:

Epilepsy_________________ High Blood Pressure/High Cholesterol________________

Ovarian Cancer____________ Goiter____

Liver Cancer______________ Heart attack before age 55___________________________

Colon Cancer______________ Any inherited disorder in your family?________________

Breast Cancer_____________ Heart/Liver/Kidney/Lung Disease____________________

Arthritis__________________ Crohns or Colitis_______________

Diabetes__________________ Ulcer (duodenal or Gastric)___________________________

Triglycerides____________ Irritable Bowel Syndrome____________________________

Obesity___________________ Any bleeding or clotting disorders?___________________

Depression_________________ Anything else we should know?_______________________

Alcoholism_________________ ____

Reviewing Providers______________________________Date:__________________________

Social History:

**Circle All That Apply*

Caffeine (Coffee, Soda, Etc)

Current Use Yes No

Tobacco

Current Use? Yes No

Which ones? Cigarettes Pipe Cigars Chewing Tobacco

Amount?____

How long?____

If stopped, when?____

Alcohol (Beer, Hard liquor, etc.)

Current Use? Yes No, Last drink?____________________

Which ones? Beer Liquor Wine

Previous Use Yes No

Type/Amount?____

How long?____

If stopped, when?____

Recreational Drugs (Ecstasy, Marijuana, Etc)

Current Use? Yes No

Which Drugs? ____

Amount?____

How long?____

If stopped, when?____

IV Drugs (Cocaine, Heroin, etc)

Current Use? Yes No

Which Drugs? ____

Amount?____

How long?____

If stopped, when?____

Procedural History

Name: ______________________________________ Date: ___________________

Please check all symptoms that you have experienced recently (i.e. in the last few weeks). Only check off symptoms that occurred before that when specifically asked (“ever in your life”). Response is considered negative if left unchecked.

In the past 3 years have you had a: *(Please include the date of the test on line provided)*

Stool tested for blood ______________

Colonoscopy_____________

Blood Cholesterol Level_____________

Prostatic Specific antigen test (PSA)________

Chest X-ray____________

Electrocardiogram (ECG)___________

Prostate Check______________

Pap Smear and Pelvic examination_________

Ct Scan of abdomen______________

Liver Biopsy__________________

ERCP or EUS ____________

Ultrasound of Abdomen____________

Skin Exam_______________

MRI of Abdomen_________________

Mammogram_____________________

Upper Endoscopy_________________

Stool Blood Test__________________

Echocardiogram__________________

Cardiac Stress Test________________

Bone Density Scan___________________

Review of Systems Questionnaire

Constitutional-
□ Activity Change
□ Appetite Change
□ Fever or chills
□ Sweating
□ Fatigue
□ Fever
□ Unexpected wt Change
HENT
□ Congestion
□ Dental Problem
□ Drooling
□ Ear Discharge
□ Ear Pain
□ Facial Swelling
□ Hearing Loss
□ Mouth Sores
□ Nosebleeds
□ Postnasal Drip
□ Sinus pressure
□ Sneezing
□ Sore Throat
□ Trouble Swallowing

Eyes-
□ Eye Discharge
□ Eye Itching
□ Eye Pain
□ Eye Redness
□ Photophobia
□ Visual Disturbance
Respiratory
□ Apnea
□ Chest Tightness
□ Choking
□ Cough
□ Shortness of breath
□ Wheezing
Cardiovascular
□ Chest Pain
□ Leg Swelling
□ Palpitations
GI
□ Abdominal Distention
□ Abdominal Pain
□ Anal Bleeding
□ Blood in stool
□ Constipation
□ Diarrhea
□ Nausea
□ Rectal Pain
□ Vomiting

Endocrine
□ Cold Intolerance
□ Heat Intolerance
□ Excessive Thirst
□ Excessive Hunger
□ Excessive Urination
GU
□ Difficulty urinating
□ Dysuria
□ Leakage of Urine
□ Flank Pain

□ Frequency
□ Genital Sore
□ Blood in Urine
□ Penile Discharge
□ Penile Pain
□ Penile Swelling
□ Scrotal Swelling
□ Testicular Pain
□ Urgency
□ Urine decreased
Musc
□ Joint Pain
□ Back Pain
□ Gait problem
□ Joint Swelling
□ Muscle Pain
□ Neck pain
□ Neck Stiffness
Skin
□ Color change

□ Pallor
□ Rash
□ Wound

Allerg/Immuno
□ Environmental Allergies
□ Food Allergies
□ Immunocompromised
Neurological
□ Dizziness
□ Facial Asymmetry
□ Headaches
□ Light-headedness
□ Numbness
□ Seizures
□ Speech Difficulty
□ Fainting
□ Tremors
□ Weakness

Hematologic
□ Swollen Glands
□ Bruises/bleeds easily
Psychiatric
□ Agitation
□ Behavior problem
□ Confusion
□ Decrease concentration
□ Depression
□ Nervous/anxious
□ Self-injury
□ Sleep disturbance
□ Suicidal ideas

Disclosure of Beneficial Interest MEC

IF YOU ARE IN NEED OF AN ENDOSCOPIC EXAMINATION, **DRS. COX, DESI, VACHON, HARRIS, HAGAN AND PICHNEY** SOMETIMES ARRANGE TO DO THESE TESTS AT THE MARYLAND ENDOSCOPY CENTER, LLC. THIS IS A FACILITY LOCATED IN THE TOWSON AREA THAT IS JOINTLY OWNED BY A NUMBER OF PHYSICIANS AND AMSURG. DRS. COX, VACHON, DESI AND PICHNEY HAVE AN OWNERSHIP INTEREST IN THE MARYLAND ENDOSCOPY CENTER, LLC.

IF YOU WOULD PREFER OT HAVE YOUR TESTS AT A FACILITY OTHER THAN THE MARYLAND ENDOSCOPY CENTER, LLC, WE WILL ACCOMMODATE YOU AT ANOTHER FACILITY IF YOUR INSURANCE PERMITS IT. WE ARE REQUIRED BY LAW TO GIVE THIS NOTICE TO YOU AND OBTAIN YOUR WRITTEN ACKNOWLEDGEMENT OF NOTIFICATION.

I, ______________________________, ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED THIS NOTICE.

DATE: ___ / ____ / ____

PATIENT SIGNATURE:____

***********CONSENT AND ASSIGNMENT************

PLEASE READ BEFORE SIGNING

*****Medicare or Medicaid*****

I authorize any holder of medical or other information about me to release to the Social Security Administration, to the Centers for Medicare and Medicaid Services or their administrators or other third party agents, and to any state Medicaid program any information needed for this or a related Medicare or Medicaid reimbursement claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

*****Blue Shield of Maryland*****

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process any and all claims. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

*****Managed Care*****

I understand that, without an authorization/referral required by my insurance company, I may be financially responsible for any charges incurred. I also understand that if my insurance carrier denies payment because a service or provider is not covered, I am financially responsible for any charges not covered by my insurance.

*****Insurance Assignment*****

I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim(s). I understand that if my insurance carrier denies payment, I am financially responsible for any charges not covered by my insurance. I further understand that I have the right to file an appeal with my insurance carrier pursuant to its appeal process to dispute any claim denial, but that I may be responsible for paying any charges associated with my account when they become due even if an appeal is pending.

*****Legal Assignment*** (applicable to Physician Service)**

I expressly agree that, in the event of non-payment, my account may be forwarded to a collection agency. If this matter is referred for collection, I agree to pay an attorney's fee of twenty-five percent (25%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom I consider reasonable, and any and all court costs incurred therewith, as well as private process server fees.

*****Guarantee*****

I understand that all bills are payable and become due upon presentation. In consideration for providing services to me, I absolutely and unconditionally guarantee Mercy Health Services, and its successors and assigns, full and complete payment of all amounts due, together with any collection costs, and reasonable attorney's fees.

I authorize a copy of this authorization to be used in place of the original.

Signature:

Signature of patient, Responsible Party, Parent or Legal Guardian

*****Consent to Contact via Telephone*****

I authorize Mercy Health Services* or its collection agency to contact me, including using a pre-recorded voice message and/or automatic dialing device, regarding my insurance, account, billing, or collection activity. Mercy Health Services or its collection agency may contact me at any telephone number associated with my account, including my home, office, or cell phone number, which may result in charges from my cell phone carrier.

I understand that my consent will remain in effect until I revoke it, but that I may withdraw my consent to be contacted at any time, or change my instructions regarding how I may be contacted, by notifying Mercy Health Services' Billing Office at: (410)332-9674.

Signature:

Signature of patient, Responsible Party, Parent or Legal Guardian

*For the purpose of this Notice, "Mercy Health Services" includes Mercy Medical Center, Inc., Stella Maris, Inc., St. Paul Place Specialists, Inc., Maryland Family Care, Inc., and all other affiliated health care providers

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Consent of Payment

The Center for Inflammatory Bowel & Colorectal Diseases (DRS. Harris, Vachon, and Hagan) and the Center for Liver and Hepatobiliary Disease (DRS. Thuluvath, Maheshwari and Yoo) are Regulated Outpatient Facilities.

This pertains to the facility located at 301 St. Paul Place, Baltimore, MD 21202.

As such patients will receive two bills for services provided in this center. One bill is for the physician and one bill is for the facility. Depending on your insurance coverage you may be responsible for a portion or the entire bill. All charges are billed to the pateints insurance company to determine the amount of pateint responsibilty. Please contact your insurance carrier to determine the co-pay, deductible and/or coinsurance amounts.

If we may be of any assistance, or if you have questions, please contact the patient accounting customer service lines at **410-951-1700.**

I have read and understand the above statement as it relates to regulated facility charges:

______________________________ ______________________________

(Patient name-Printed) **(Date of Birth)**

____

(Patient Signature)

The Institute for Digestive Health and Liver Disease

Authorization for Release of Medical Records

Patient Information:

Last Name		First Name		M.I.
Address	City	State	Zip Code	
Date of Birth		Social Security Number		

I hereby authorize you to release to the Institute for Digestive Health and Liver Disease of Mercy Medical Center a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this protected health information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

____

***Patient or Guardian Signature** **Date**

Please include the following items:

*Admission Notes * Progress Notes

* Discharge Summary * Pathology Reports

* Operative Reports *Consultation Notes

*EKG'S * Laboratory Tests

* X-ray Reports * Stress Tests

Remarks:

____

____

This authorization will expire on: ____

Phone: (410)-332-9356 Fax: (410)783-5884

Acknowledgement of Notice of Privacy Practices

I ACKNOWLEDGE THAT I RECEIVED MERCY HEALTH SERVICES NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT ME MAY BE USED AND DISCLOSED, MY RIGHTS REGARDING THE USE AND DISCLOSURE OF THIS INFORMATION AND HOW I OBTAIN ACCESS TO THIS INFORMAITON.

____

X **Signature**

____

X **Guardian**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Mercy Health Services* (“MHS”) is required by law to maintain the privacy of identifiable information that relates to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to medical information. This notice also discusses the uses and disclosures MHS will make of your medical information. MHS must comply with the provisions of this notice, although MHS reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all medical information that MHS maintains. You can always request a dated copy of our most current privacy notice from any of our facilities or you can access it on our website at www.MDmercy.com.

Permitted Uses & Disclosures

MHS may use or disclose medical information about you, without your authorization, for purposes related to/for:

- **Treatment:** Treatment means the coordination of your care between various healthcare providers and specialists for consultations. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review

- your medical records to assess whether you have potentially complicating conditions such as diabetes.
- **Payment:** Payment refers to activities related to verifying your level of insurance benefits, requesting authorizations for treatment and referrals for special tests, and billing/administrative purposes. For example, MHS may need to provide information to your insurance plan about your medical condition in order to determine whether the proposed course of treatment will be covered.
- **Health Care Operations:** Health care operations include quality assurance, case management, patient complaints, audits, and physician reviews. For example, MHS may use your medical information to evaluate the performance of our staff in caring for you.
- **Friends/Family:** When friends/family are involved in your care or payment for your care, MHS may allow them to pick up medical supplies, x-rays, or filled prescriptions on your behalf. We may also include certain non-treatment information in a facility directory. If you are available, we will allow you to object to these disclosures. If you are unavailable, MHS will use professional judgment to determine what is in your best interest.
- **Appointments & Other Health Benefits:** MHS may contact you to remind you about your appointments and bring to your attention alternative treatment suggestions and other health related benefits.
- **Fundraising:** MHS may contact you as part of our fundraising efforts to support our healthcare mission. You have a right to opt out of receiving such information.
- **Organ & Tissue Donation:** MHS may disclose your medical information to organizations that handle organ and tissue procurement and donations.
- **Military Authorities:** If you are a member of the U.S. Armed Forces or foreign military, MHS may release medical information about you to appropriate military command authorities.
- **Workers' Compensation:** MHS may disclose medical information to comply with workers' compensation laws.
- **Public Health Risks:** MHS may disclose your medical information to public health officials for the purpose of preventing or controlling disease, injury or disability, including reporting suspected child abuse or neglect.
- **Health Oversight:** MHS may disclose your medical information to federal or state agencies that oversee the health care system, government programs, and enforcement of civil rights laws for activities such as audits, investigations, or inspections.

- **Legal Proceedings:** MHS may disclose your medical information in response to a court order, subpoena, or other lawful process.
- **Law Enforcement:** MHS may disclose your medical information to law enforcement officials to aid in the search for a criminal or fugitive or a criminal investigation.
- **Coroners, Medical Examiners, and Funeral Directors:** MHS may disclose your medical information to identify a deceased person, determine cause of death, and to help funeral directors carry out their duties.
- **National Security:** MHS may disclose your medical information to authorized federal authorities for national security activities permissible by law or to protect the President of the United States or other authorized persons.
- **Inmates:** MHS may provide a correctional facility with an inmate's medical information for their health care and to protect the health and safety of others.
- **Research:** MHS may disclose your medical information to researchers that have received proper approval from our research review board.
- **Health or Safety:** As permitted by applicable law and ethical conduct, MHS may use and disclose medical information if its staff believes, in good faith, that such use or disclosure is necessary to prevent serious harm to you and to others. We may share your information for disaster relief efforts or in emergency situations.
- **Maryland Health Information Exchange/CRISP:** MHS has chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide internet-based health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org

Your Rights

Other uses and disclosures of your health information will be made only with your authorization. You have the right to revoke such authorization. Uses and disclosures for which an authorization is required include

Your Rights

As a patient of Mercy Health Services, you have the right to:

- **Psychotherapy Notes.** MHS must obtain an authorization for any use or disclosure of your psychotherapy notes except as required by law or to carry out the following treatment, payment or health care operations:
    - Use by the originator of the psychotherapy notes for treatment;
    - Use or disclosure by MHS for its own training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
    - Use or disclosure by MHS to defend itself in a legal action or other proceeding brought by you.
- **Marketing.** MHS must obtain an authorization for any use or disclosure of protected health information for marketing purposes except if the communication is in the form of a face to face communication made by MHS or an MHS workforce member to you, or a promotion gift of minimal or nominal value provided to you by MHS.
- **Sale of Protected Health Information.** MHS must obtain an authorization for any disclosure of protected health information which would amount to a sale of protected health information.

Your Rights

As a patient of Mercy Health Services, you have the right to:

- Request to view and request a copy of your medical records. A fee may be charged for the cost of copying or mailing your records; however, you will not be denied copies if you cannot afford to pay for them.
- Request to amend your medical information.
- Request an accounting of certain disclosures of medical information.
- Opt out of our facility directory

- Opt out of receiving fundraising communications by notifying the Mercy Health Foundation at 410-332-9874 or at updatemyrecord@mdmercy.com.
- Request restrictions on our use of your medical information for treatment, payment, health care operations and friends/family; however MHS is not required to accept your request. MHS is required to agree to restrictions on disclosures of your medical information to a health plan for payment purposes related to a specific service when you have prepaid for the service(s) in full; however, if the service is part of a group of services “bundled” for health plan billing purposes, it may not be possible for MHS to restrict the disclosure.
- Request that MHS communicate with you in a certain way or at a certain location for confidentiality.
- Receive this Notice of Privacy Practices in a paper copy, even if you initially received it in an electronic format or viewed it on MHS’ website.

Mercy Health Service’s Duties

We are required by law to maintain the privacy of your protected health information, and to provide you with a copy of our Privacy Practices and to notify you in the event of a breach of your protected health information. We are required by law to abide by the statements within this Notice of Privacy Practices, **effective August 1, 2013**. Mercy Health Services reserves the right to make any necessary changes and updates to our Privacy Practices, and these new provisions affect all protected health information that we maintain. If we change any of our Privacy Practices, an updated Notice of Privacy Practices will be made available upon request and posted in a clear and prominent location.

Should you have a complaint, question, or feel that your privacy rights have been violated, please contact our Privacy Officer at (410) 576-LAWS (5297). You may also file a complaint with the Department of Health and Human Services Office of Civil Rights at (866) 627-7748. We will not retaliate against you for filing a complaint.

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