RETINA OF COASTAL CAROLINA

NEW PATIENT REGISTRATION FORM FOR MINORS

LAST NAME of MINOR_____FIRST NAME_____MIDDLE_____

MAILING ADDRESS _____

STREET ADDRESS _____

CITY _____ STATE _____ZIP CODE _____

HOME # _____ CELL #:_____ DATE OF BIRTH _____ SEX (M/F) _____

PREFERRED LANGUAGE _____ RACE_____ HISPANIC OR LATINO: YES / NO

INFORMATION OF PARENT OR GUARDIAN

Relationship to Minor: Parent _____ Guardian _____ Other (Please Specify) _____

NAME_____ DOB_____ SOCIAL SECURITY# _____

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE#_____

EMAIL_____ EMPLOYER INFORMATION: _____

RESPONSIBLE PARTY (Parent, Guardian or Power of Attorney)

NAME_____ PHONE_____

ADDRESS IF DIFFERENT FROM ABOVE:_____

DOCTOR INFORMATION

EYE DOCTOR_____ CITY_____ PHONE_____

PEDIATRICIAN'S NAME _____ CITY_____ PHONE_____

REFERRAL INFORMATION

Patient was referred by (Circle One): Doctor _____ / Friend or Patient / Newspaper / Radio / Television /

Yellow Pages / Internet / Other: _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ ID#_____

SECONDARY INSURANCE_____ ID#_____

TERTIARY INSURANCE_____ ID#_____

HOW WILL YOU PAY FOR ANY COPAYS, DEDUCTIBLES COINSURANCE OR *NON COVERED* SERVICES?

( ) CASH ( ) CHECK ( ) CREDIT CARD

ASSIGNMENT AND RELEASE

I give my permission for Retina of Coastal Carolina to: 1) release to the Social Security Administration or other insurance carrier, information concerning my insurance claim, 2) file my insurance claim with Medicare or an insurance company and assign the benefits paid to Retina of Coastal Carolina, 3) contact any medical professional whom my doctor deems necessary for the furtherance of my medical care, and 4) to leave a message to remind me of a medical/surgical appointment on any answering machine at my phone number or with any person answering my phone unless otherwise noted below.

I understand that: 1) my consent is good for all services for the remainder of my life, and 2) I am responsible for any unpaid balance not paid by my insurance company.

( ) I do **NOT** wish to have messages about my medical/surgical appointments left on my answering machine or with anyone other than me.

FINANCIAL POLICY

Thank you for choosing ROCC for your healthcare needs. Please understand that payment of your bill is considered your responsibility. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. To achieve the practice goals of providing the finest medical care at the lowest possible cost and meet our financial obligations, we need assistance in the following.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT.

In regards to insurance plans, all copays, deductibles, and coinsurances are due at time of service unless other arrangements were made. Payment is due a minimum of one (1) week prior to any scheduled surgery.

If you have insurance coverage, we will file the claim for you. Payment for treatment remains your responsibility. Your insurance policy is a contract between you and your insurance company. **IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSBILITY TO OBTAIN AND PROVIDE THIS.**

If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier. Please be aware that some of the services provided may be non-covered and not considered reasonable and necessary under Medicare and/or other medical insurance. We will inform you in advance of such charges.

We will check the status of your insurance benefits prior to all visits. If your deductible has not been met, we will require payment of that amount and any additional coinsurance or copay responsibility. Payments are applied to your account promptly and any credit balance after insurance has paid will be refunded to you within 30 days. Please note that these are estimates only and are subject to change when your claim is reviewed and submitted to your insurance company. The parent and/or adult accompanying a minor is responsible for full payment at time of service.

If you do not have insurance coverage, a patient financial counselor is available to provide you with an estimate of charges for your visit. **THIS IS AN ESTIMATE ONLY** and may vary depending on tests or treatments deemed necessary upon examination by the doctor.

Return checks may be subject to any bank fees and a collection fee of $25.00 per check.

If you have any questions about financial arrangements, please feel free to talk with any of our Patient Financial Counselors at 910-254-2023 ext 126. We will make every effort to clarify any concerns regarding your financial responsibility.

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS TERMS.

SIGNATURE OF RESPONSIBLE PARTY_____ DATE_____

PRINT NAME _____ DATE OF BIRTH_____

retina of coastal carolina

Igor Westra, MD

"Providing the Best in Retina Care"

Henry Holt, MD

Medical and Surgical Treatment of Diseases of the Vitreous and Retina since 1997

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices of Retina of Coastal Carolina originally dated April 14, 2003, amended September 2011 and revised October 1, 2019.

Print Name: _____
Patient Date of Birth

Signature: _____ Dated: _____

Print Name of Guardian/Parent Signing on behalf of Minor/Incapacitated Person:

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____

Prepared By _____ Date: _____

RETINA OF COASTAL CAROLINA

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed covered by authorization includes:

Clinical Billing/Insurance Pharmacy Appointment Demographic Info

Persons to Whom Information May Be Disclosed

Name of person	DOB	Relationship
Name of person	DOB	Relationship
Name of person	DOB	Relationship

Expiration Date of Authorization
This authorization is effective through treatment unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Retina of Coastal Carolina. You should contact the Office Administrator to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of patient

Signature of Patient Date

Signature of Patient Representative Relationship of Patient Representative

retina of coastal carolina

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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Westra/Dr. Holt and/or such assistants as may be designated by him to administer dilating eye drops on each visit. The eye drops are necessary to diagnose my condition.

_____

PRINT Patient Name

_____ _____

Patient Signature (or authorized person) Date

_____ _____

Witness Date

www.retinaofcoastalcarolina.com

Wilmington Office
1801 N.H. Medical Park Drive
Wilmington, NC 28403

Jacksonville Office
1899 N. Marine Blvd., #400
Jacksonville, NC 28546

Supply Office
14 Doctors Circle, #4
Supply, NC 28462

Southport Office
5211 Eason Street, Suite 1
Southport, NC 28461

910-254-2023 | **Toll Free: 888-2RETINA** | **Fax: 910-254-0242**

Intake and History Form

Name: _____ Date: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)

- [ ] Kidney: Kidney Biopsy
- [ ] Kidney: Kidney Stone Removal
- [ ] Kidney: Kidney Transplant
- [ ] Kidney: Nephrectomy
- [ ] Liver: Hepatectomy
- [ ] Liver: Liver Transplant
- [ ] Live: Shunt

- [ ] Uterus (Hysterectomy): Fibroids
- [ ] Uterus (Hysterectomy): Uterine Cancer
- [ ] Uterus (Hysterectomy): Cervical Cancer
- [ ] NONE
- [ ] Other

_____
_____
_____

Past Ocular History

Allergic conjunctivitis	L	R
Blepharitis	L	R
Cataract	L	R
DSAEK	L	R
Corneal Dystrophy	L	R
Diabetic Retinopathy	L	R
Dry Eyes	L	R
Glaucoma	L	R
Macular Degeneration	L	R
Macular ERM	L	R
Narrow Angles	L	R
Ocular Hypertension	L	R
Ophthalmic Migraine	L	R
Pseudoexfoliation	L	R
Retinal Tear	L	R
Strabismus	L	R
PVD	L	R
Vitreous Floaters	L	R

Past Ocular Surgery

YEA

Blepharoplasty	L	R
Cataract Surgery	L	R
Corneal Transplant	L	R
DSAEK	L	R
Eye Muscle Surgery	L	R
Intravitreal Injections	L	R
LTP	L	R
PRK	L	R
Ptosis repair	L	R
Punctal Plugs	L	R
Strabismus	L	R
Retinal laser	L	R
Trabeculectomy	L	R
Tube shunt	L	R
Yag capsulotomy	L	R
	L	R
	L	R

Medications

List all current medications:

_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____

Allergies

List all allergies and reactions if known:

_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Started Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? _____

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Family History

M=Mother F=Father B=Brother S=Sister

M=Mother F=Father B=Brother S=Sister

☐	Diabetes	☐ M	☐ F	☐ B	☐ S	Heart Disease	☐ M	☐ F	☐ B	☐ S
☐	Hypertension	☐ M	☐ F	☐ B	☐ S	Migraine	☐ M	☐ F	☐ B	☐ S
☐	Glaucoma	☐ M	☐ F	☐ B	☐ S	Cancer	☐ M	☐ F	☐ B	☐ S
☐	Blindness	☐ M	☐ F	☐ B	☐ S	CVA	☐ M	☐ F	☐ B	☐ S
☐	Cataract	☐ M	☐ F	☐ B	☐ S	Macular Degeneration	☐ M	☐ F	☐ B	☐ S
☐	Strabismus	☐ M	☐ F	☐ B	☐ S	Retinal Detachment	☐ M	☐ F	☐ B	☐ S

Review of Systems

Are you currently experiencing any of the following? Please check yes or no

	System	YES	NO
Poor vision	Eyes		
Eye pain	Eyes		
Tearing	Eyes		
Redness	Eyes		
Jaw pain	Eyes		
Scalp tenderness	Eyes		
Amaurosis fugax	Eyes		
Loss of vision	Eyes		
Uncontrolled blood pressure	Cardiovascular		
Uncontrolled blood sugar	Endocrine		
Weight loss	Constitutional		
Stuffy nose	ENT		
Dry mouth	ENT		
Congestion	Respiratory		
Shortness of breath	Respiratory		
Upset stomach	Gastrointestinal		
Incontinence	Gastrointestinal		
Arthritis	Musculoskeletal		
Headache	Neurological		
Anxiety	Psychiatric		
Allergies	Allergic/Immunologic		

Other Symptoms: _____

Medical Alerts

Please check yes or no for the following:

Alert	YES	NO
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to Dilation Drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Narrow angles		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within past two years		
Steroid responder		

Other Symptoms: _____

Retina of Coastal Carolina

1801 New Hanover Medical Park Drive
Wilmington, North Carolina 28403

1899 N Marine Blvd, Suite 400
Jacksonville, NC 28546

14 Doctors Circle, Unit 4
Supply, North Carolina 28462

5211 Eason St, Suite 1
Southport, NC 28461

910-254-2023 or 888-273-8462

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. 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 would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will 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 recommend for you such as; making a determination of eligibility or coverage for insurance benefits, and reviewing services provided to you for medical necessity.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and, if you are unavailable, we may leave the information with another member of your household or on your voice mail. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. 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. We may also use and disclose your protected health information for other marketing activities upon your written authorization

Uses and Disclosures of Protected Health Information 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 this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object
We may use and disclose your protected health information in the following instances. You can agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: 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 on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public 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.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child 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.

Food and Drug Administration: 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, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

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 include (1) legal processes and otherwise required by law, (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 the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, 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 of a person or the public. We may also 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 (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

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 prison and your physician created or received your protected health information while providing care to you.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these 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 designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you 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.

Your physician is not required to agree to a restriction that you may request. If 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. 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. Please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also 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. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

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 in a designated record set for as long as we maintain this information. 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 Contact to determine 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 to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. 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 contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact at (910)254-2023 or (888)273-8462 for further information about the complaint process.

This revised notice was published and becomes effective on October 1, 2019, which replaces the earlier revised notice dated September 16, 2013 and Amended Notice dated and in effect as of September 20, 2011.