



W: WCMIOOrtho.com  
P: 352-556-4823  
F: 352-556-4824

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Are you:  Right-handed  Left-handed

Preferred Pharmacy (with cross streets): \_\_\_\_\_

How did you hear about WCMIO? \_\_\_\_\_

**ONLY IF PATIENT IS A MINOR- RESPONSIBLE PARTY INFORMATION- Please fill in ALL blanks.**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  M  F Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

**Minor Pre-Authorization for Medical Care**

I request and authorize West Coast Musculoskeletal Institute and its personnel to deliver medical care to my child listed above.

Guardians Name (Print): \_\_\_\_\_ Guardians Signature: \_\_\_\_\_

Relationship to patient (Print): \_\_\_\_\_ Date: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Age: \_\_\_\_\_ Problem with:  Right Extremity  Left Extremity

Why are you here today? \_\_\_\_\_

**SYMPTOMS:**

Location: \_\_\_\_\_

(Where is the pain? Does it travel to other areas?)

Quality: \_\_\_\_\_

(Is the pain dull, throbbing, sharp? If bump, is it warm, tender, red?)

Severity: \_\_\_\_\_

(How severe on a scale of 1-10 with 10 being most severe?)

Duration: \_\_\_\_\_

(How long have you had this pain/problem? When did it start?)

Time: \_\_\_\_\_

(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?)

Context: \_\_\_\_\_

(What were you doing at the onset of the pain/problem?)

Associated signs/symptoms: \_\_\_\_\_

(Do you have numbness? Abnormal sounds: cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?)

Modifying factors: \_\_\_\_\_

(What makes the problem worse or better? Example: Activities)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**PAST HISTORY OF PRESENT ILLNESS:**

Have you ever experienced any injury or symptoms regarding this body part?  Yes  No

If so, please provide details: \_\_\_\_\_

Please list any hobbies/sports you enjoy:

Which of the above activities are you unable to perform due to your pain?

Have you seen any other physicians regarding THIS condition prior to coming to our office:  Yes  No

<u>Doctor</u>	<u>When</u>	<u>Tests</u>	<u>Results</u>	<u>Treatment</u>

**PAST MEDICAL HISTORY:** Have you ever had any of the following? *Please circle all pertinent information:*

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> AIDS or HIV        | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Infectious Mono       | <input type="checkbox"/> Polio           | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Diphtheria        | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Back Trouble       | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Whooping cough      |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Measles               | <input type="checkbox"/> Sleep Apnea     | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Bleeding Tendency  | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Migraine Headache     | <input type="checkbox"/> Smallpox        | _____  |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hemorrhoids       | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke          | _____  |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Dementia          | <input type="checkbox"/> COPD                  | <input type="checkbox"/> Fibromyalgia    | _____  |

Please list **all medications** you are taking (Include non-prescription and herbal supplements):

<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>

**Are you allergic to any medications?**

Medication	Reaction	Tape Allergy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	Latex Allergy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____			

**Past Surgical/Hospitalization History:**

<u>Date</u>	<u>Surgery/Illness</u>	<u>Doctor</u>	<u>Hospital, City, State</u>

Signature of Patient/Parent of Minor/Legal Representative

Date

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**PATIENT SOCIAL HISTORY:**

Marital Status

- Single
- Married
- Divorced
- Widow

Use of Alcohol

- Never
- Rarely
- Moderate
- Daily

Use of Tobacco

- Never
- Previously, but quit
- Currently \_\_\_\_\_ packs per day

Living Situation

- With Family
- With Friends
- Alone
- Other \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

Age	Conditions or Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____

**REVIEW OF SYSTEMS: Please circle any personal history below:**

**Musculoskeletal**

- Joint Pain  No  Yes
- Joint stiffness or swelling  No  Yes
- Weakness of muscles/joints  No  Yes
- Muscle pain or cramps  No  Yes
- Back pain  No  Yes
- Cold Extremities  No  Yes
- Difficulty in walking  No  Yes

**Constitutional Symptoms**

- Bad general health lately  No  Yes
- Recent weight change  No  Yes
- Fever  No  Yes
- Fatigue  No  Yes
- Headaches  No  Yes

**Ears/Nose/Mouth/Throat**

- Hearing loss or ringing  No  Yes
- Earaches or drainage  No  Yes
- Chronic Sinus Problems  No  Yes
- Nose Bleeds  No  Yes
- Bleeding gums  No  Yes
- Sore throat or voice change  No  Yes
- Swollen glands in neck  No  Yes

**Cardiovascular**

- Heart Trouble  No  Yes
- Chest pain or angina  No  Yes
- Palpitations  No  Yes
- Shortness of breath while walking  No  Yes
- Swelling of feet, ankles or hands  No  Yes

**Genitourinary**

- Frequent urination  No  Yes
- Burning or painful urination  No  Yes
- Blood in urine  No  Yes
- Incontinence or dribbling  No  Yes
- F-number of pregnancies \_\_\_\_\_
- F-number of deliveries \_\_\_\_\_

**Integumentary (skin, breast)**

- Rash or itching  No  Yes
- Changes in skin color  No  Yes
- Varicose veins  No  Yes
- Breast pain  No  Yes
- Breast lump  No  Yes

**Neurological**

- Light headed or dizziness  No  Yes
- Numbness/tingling sensations  No  Yes
- Tremors  No  Yes
- Paralysis  No  Yes

**Hematologic/ Lymphatic**

- Bleeding/bruising tendency  No  Yes
- Anemia  No  Yes
- Enlarged glands  No  Yes
- Slow to heal after cuts  No  Yes

**Endocrine**

- Excessive thirst or urination  No  Yes
- Heat or cold intolerance  No  Yes
- Dry Skin  No  Yes

**Psychiatric**

- Memory loss or confusion  No  Yes
- Nervousness/ Anxiety  No  Yes
- Depression  No  Yes
- Insomnia  No  Yes

**Gastrointestinal**

- Loss of appetite  No  Yes
- Nausea or vomiting  No  Yes
- Frequent diarrhea  No  Yes
- Constipation  No  Yes
- Rectal bleeding/ blood in stool  No  Yes
- Abdominal pain  No  Yes

**Respiratory**

- Chronic or frequent coughs  No  Yes
- Spitting up blood  No  Yes
- Shortness of breath  No  Yes
- Wheezing  No  Yes

**Eyes**

- Eye disease or injury  No  Yes
- Wear glasses/ contact lens  No  Yes
- Blurred or double vision  No  Yes

**Allergic/ Immunologic**

- List Food/ environmental allergies: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Patients 65 or older:** Spiritual/Cultural Preference? \_\_\_\_\_

Healthcare Proxy?  Yes  No Name: \_\_\_\_\_

Power of Attorney for Healthcare?  Yes  No Name: \_\_\_\_\_

Copy of POA?  Yes  No Do Not Resuscitate?  Yes  No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medial status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient/Parent or Minor/Legal Representative \_\_\_\_\_

Date \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Pre-Qualification Questionnaire**

Are you a Florida resident? Yes / No  
Do you have a valid Florida ID? Yes / No  
If Female, Are you pregnant? Yes / No  
Have you been arrested or charged with a crime in the past two years? Yes / No  
(If yes, please describe)

\_\_\_\_\_  
\_\_\_\_\_

Are you currently on parole or probation? Yes / No **(If yes, please see clinic manager)**

Have you been evaluated for medical marijuana use by another physician in the past? Yes / No  
(If yes, please give name of practice, doctor, date seen, and condition for evaluation)

\_\_\_\_\_  
\_\_\_\_\_

Have you been denied a recommendation for medical marijuana use by another physician in the past? Yes / No  
(If yes, please explain)

\_\_\_\_\_  
\_\_\_\_\_

Are you currently attending, or have you attended any substance abuse or rehabilitation program? Yes / No  
(If yes, please provide details)

\_\_\_\_\_  
\_\_\_\_\_

Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No  
(If yes, please provide details)

\_\_\_\_\_  
\_\_\_\_\_

Did you bring any medical records with you today? Yes / No (If yes, what did you bring)

\_\_\_\_\_  
\_\_\_\_\_

Do you currently use marijuana? Yes / No (If yes, how often)

\_\_\_\_\_  
\_\_\_\_\_

Do you currently drink alcohol? Yes / No (If yes, how often)

\_\_\_\_\_  
\_\_\_\_\_

Do you currently use cocaine, methamphetamine, opiates, heroin, or other street drugs? Yes / No  
(If yes, please explain)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent or Minor/Legal Representative

\_\_\_\_\_  
Date

## Financial Policy

Welcome to our Office

At West Coast Musculoskeletal Institute, we are committed to providing you with the highest level of service and quality care, and we regard your understanding of our financial policies and those of your insurance as an essential element of your care and treatment. If you have any question regarding your account, charges, insurance, or payments, please ask to speak with one of our billing representatives.

### Payment Policy

Payment in full is expected at the time service is rendered. For your convenience, we accept cash, credit or debit cards at your appointment. We do not accept checks or American Express.

### Insurance Plans

If you are insured, we will bill those insurance plans with which we have an agreement. **It is ultimately your responsibility to be aware of the details of your insurance plan.** If you are not familiar with the allowable benefits of your insurance, we recommend that you contact your insurance company prior to your visit so that you may understand what services are or are not covered. Please note that if your insurance requires a co-pay, co-insurance, or deductible, it will be collected at the time of your visit. In the event that your insurance determines that a service is “non-covered,” we will bill you and payment will be due upon receipt of that statement.

### Self-Pay Accounts

If you do not have a valid insurance plan to cover the cost of services, you will be required to make full payment at the time services are rendered, unless other arrangements have been made in advance with our office.

### Outstanding Balances

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify the billing department immediately and we will gladly work out a payment plan with you. Please note that in the event of non-payment, the account may be turned over to an outside collection agency and the expenses will be added to your account balance. Any payment made by check for an outstanding balance that is returned for insufficient funds or due to a “stop payment” will result in a \$25.00 fee.

### Referrals

If your insurance plan requires a referral, we prefer that the referral is provided before making an appointment with our office. We do our best to obtain referrals from your primary care doctor, but in the event that we do not receive it, your appointment, if one is made, will need to be rescheduled until the necessary paperwork is obtained.

I understand that WCMI agrees to bill my insurance as a courtesy, and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for all payment of services.

## AUTHORIZATION AND ASSIGNMENT

I hereby authorize West Coast Musculoskeletal Institute to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to West Coast Musculoskeletal Institute (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover Medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney’s fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

\_\_\_\_\_  
Name of Patient (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

**PATIENT PRIVACY QUESTIONNAIRE**

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

2. Please list the family members or significant others, if any, whom we may inform about your medical condition

**ONLY IN AN EMERGENCY:**

Name: \_\_\_\_\_  
Name: \_\_\_\_\_

Phone #: \_\_\_\_\_  
Phone #: \_\_\_\_\_

I understand that all correspondence from our office will be sent in a sealed envelope marked "**CONFIDENTIAL**".

\*\*Confidential messages (i.e., appointment reminders)  May /  May **not** be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:  
\_\_\_\_\_

I am fully aware that a cell phone is not a secure and private line.

**CONSENT TO TREAT**

*and*

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I, the undersigned, voluntarily give consent to my West Coast Musculoskeletal Institute medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. Also, I have received/reviewed a copy of the West Coast Musculoskeletal Institute's Notice of Privacy Practices and the Florida Patient Bill of Rights.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please *print* Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Legal Representative

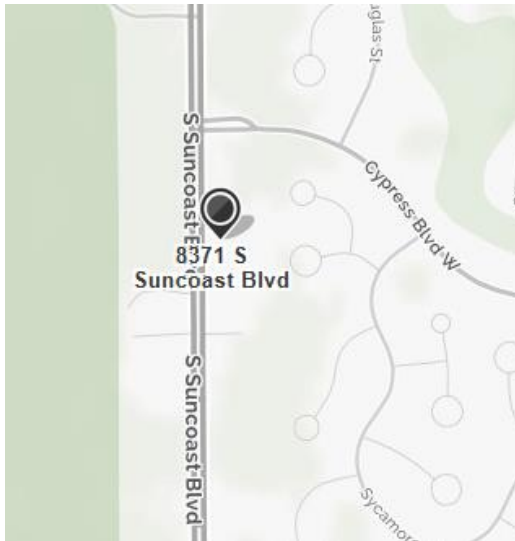
\_\_\_\_\_  
Relationship to Patient

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement for the Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

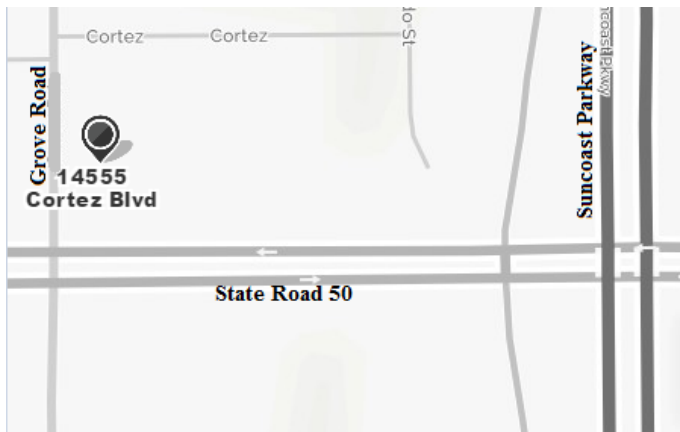
<b>Date</b>	<b>Initials</b>	<b>Reason</b>

**Office Locations**  
Citrus County



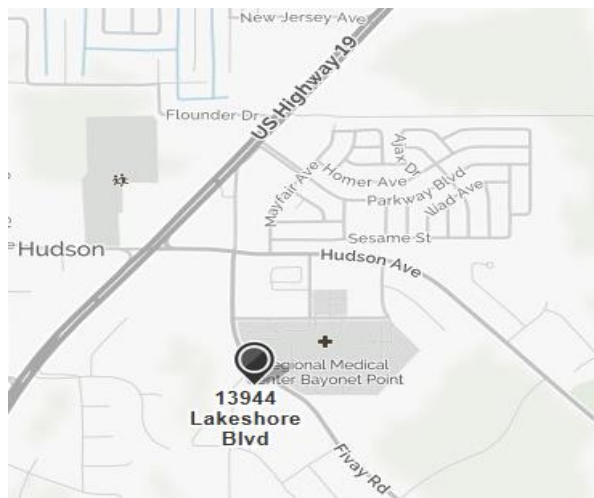
8371 South Suncoast Blvd.  
Homosassa, FL. 34446  
*South of Cypress Blvd at  
Sugar Mill Woods Entrance.*

Hernando County



14555 Cortez Blvd.  
Brooksville, FL. 34613  
*On the corner of Cortez Blvd and  
Grove Rd.*

Pasco County



13944 Lakeshore Blvd.  
Suite B,  
Hudson, FL. 34667  
*Take Hudson Avenue to  
Fivay Road. Across the  
street from Bayonet  
Point Hospital.*  
***ENTER THROUGH  
SUITE A***

**HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES**

Effective Date: March 24, 2017

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

**YOUR RIGHTS**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

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**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

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**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

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**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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**Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12months.

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**Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
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**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- 

**YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory.
  - Contact you for fundraising efforts.
  - *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- 

**In these cases, we *never* share your information unless you give us written permission:**

- Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
- 

**OUR USES AND DISCLOSURES**

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

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**Treat you**

- We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

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**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

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**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
    - Preventing disease.
    - Helping with product recalls.
    - Reporting adverse reactions to medications.
    - Reporting suspected abuse, neglect, or domestic violence.
    - Preventing or reducing a serious threat to anyone’s health or safety.
- 

**Do research**

- We can use or share your information for health research.
- 

**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
- 

**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.
- 

**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- 

**Address workers’ compensation, law enforcement, and other government requests**

- We can use or share health information about you:
    - For workers’ compensation claims.
    - For law enforcement purposes or with a law enforcement official.
    - With health oversight agencies for activities authorized by law.
    - For special government functions such as military, national security, and presidential protective services.
- 

**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- 

**OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may submit a comment or complaint about our privacy practices by:

- 1) Mail to West Coast Musculoskeletal Institute, 14555 Cortez Boulevard, Brooksville, FL. 34613;
- 2) Email to [info@wcmiortho.com](mailto:info@wcmiortho.com);
- 3) Phone (352)556-4823;
- 4) Written communication to the facility following the process outlined in our Company's Patient Rights documentation; and/or
- 5) Written communication to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

**You will not be penalized for filing a complaint.**