

Myers & Miller Podiatry, Inc

Adam M. Myers, D.P.M.
Podiatrist

Andy W. Miller, D.P.M.
Podiatrist

PATIENT INFORMATION

TODAY'S DATE _____

LAST NAME: _____ FIRST NAME & MI _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ SEX _____ FEMALE ___ MALE _____ MARTIAL STATUS: S M D W

PHONE _____ ALTERNATE PHONE _____ E-Mail _____

Your Place of mployment _____ Address _____ Phone# _____

How did you hear about us? _____ Reason for today's visit: _____

Spouse's Name _____ Spouse's Place of Employment _____

RESPONSIBLE PARTY INFORMATION SAME AS ABOVE Yes No

LAST NAME: _____ FIRST NAME & MI _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT: _____

Insured Phone _____ Alternate Phone _____ Employer Name: _____

PRIMARY INSURANCE

Insured Party: ___ Same as patient or ___ Same as Responsible Party Relationship to Patient:

Insured Party Name: _____

Insured ID _____

Number _____ Policy # _____ Insurance Company: _____

Insured Phone #: _____ Social Security#: _____ Date of Birth _____

SECONDARY INSURANCE

Insured Party: ___ Same as Patient or ___ Same as guarantor Relationship to Patient: _____

Insured Party Name _____

Insured ID Number _____ Policy # _____ Insurance Company _____

Insured Phone#: _____ Social Security# _____ Date of Birth _____

MEDICAL HISTORY

Pharmacy: _____ Location: _____

Family Physician _____ DATE OF LAST VISIT _____

BELOW IS A LIST OF DISEASES/ILLNESSES. INDICATE WITH AN "X" IF YOU CURRENTLY HAVE OR PREVIOUSLY HAD ANY OF THESE DISEASES/ILLNESSES.

YES	NO		YES	NO	
CARDIOVASCULAR			NERVOUS SYSTEM		
___	___	Phlebitis	___	___	Epilepsy/Seizures
___	___	Heart Attack	___	___	Migraine Headaches
___	___	Heart Murmur	___	___	Neuropathy
___	___	Heart Valve Problems	___	___	Loss of Balance
___	___	Stroke/TIA	___	___	Multiple Sclerosis
___	___	Blood clots in legs			
___	___	High blood pressure			
___	___	Pacemaker/Brand _____			
___	___	High Cholesterol			
					EYES
			___	___	Glaucoma
			___	___	Cataracts
PULMONARY			BONE/JOINT DISEASE		
___	___	Asthma	___	___	Arthritis
___	___	Chronic Bronchitis	___	___	Degenerative Joint Disease
___	___	Emphysema	___	___	Joint Replacement
___	___	Tuberculosis	___	___	Gout
___	___	Pneumonia	___	___	Fracture(s)
___	___	Chronic Pulmonary Disease (COPD)	___	___	Osteoporosis
GASTRONINTESTINAL SYSTEM			INFECTIOUS DISEASE		
___	___	Ulcers			
___	___	Stomach Irritation			
___	___	Hiatal Hernia	___	___	Hepatitis
___	___	Gallbladder Problems	___	___	Polio
___	___	Liver Disease	___	___	Rheumatic Fever
___	___	Hernia			
___	___	Diverticulitis			
CANCER			URINARY SYSTEM		
___	___	If yes, Please list type:	___	___	Bladder/Kidney Infections
___	___	_____	___	___	Kidney Stones
___	___	_____	___	___	Enlarged Prostate
___	___	_____			
					ENDOCRINE SYSTEM
			___	___	Diabetes
			___	___	Pancreatic Disease
			___	___	Addison's/Cushing's disease
			___	___	Thyroid Disease
GENITOURINARY			PHYCHIATRIC		
___	___	Kidney failure/Dialysis	___	___	Depression
___	___	Kidney transplant	___	___	Claustrophobia
			___	___	Anxiety
ALLERGY/MISC.			RESPIRATORY		
___	___	Eczema	___	___	Sleep Apnea
___	___	Psoriasis	___	___	COPD/Asthma
___	___	Lupus	___	___	Emphysema/TB
___	___	Rashes	___	___	Lung Mass
___	___	Food Allergy			
___	___	Medication Allergies			
___	___	Fibromyalgia/chronic fatigue			

CHILDHOOD ILLNESSES ___ Chicken Pox ___ Mumps ___ Polio ___ Rheumatic Fever

The above information is current and correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

3

MEDICATIONS: _____

ALLERGIES: _____

Hospitalizations: Include hospital name, what for, and when)

Surgeries: (Include procedure, where it was done, when, and the outcome)

FAMILY HISTORY (Please Check Appropriate boxes below)

CONDITION	YES	NO	RELATIONSHIP TO YOU	CONDITION	YES	NO	RELATIONSHIP TO YOU
Anxiety				High Blood Pressure			
Arthritis				High Cholesterol			
Asthma				HIV			
Bleeding Problems				Kidney Disease			
Cancer, Type:				Liver Disease			
Heat Attack				Osteoporosis			
Hepatitis				Seizures			
Diabetes/High Blood sugar				Stroke			
Depression				Stroke			
Epilepsy				Thyroid Problems			
Gout				Tuberculosis			
				Foot problems			

SOCIAL HISTORY

Do you use alcohol? Y N If yes, how many drinks per week on average? ____/Week
Do you use tobacco (cigarette, cigar, chewing tobacco)? Y N If yes, how much per day ____ Day.
Do you use any "street drugs"? Y N If yes, what and how often? _____
Do you use caffeine (coffee, tea, soda pos)? Y N If yes, How many cups per day? _____?Day
Job Description: _____
Hobbies: _____
Recreational/Exercise activities: _____

INJURY INFORMATION

Date of injury _____ Affected/injured Body Part: _____ Side: __ Right __ Left
Have you had prior testing for this injury (X-Ray/MRI) Yes __ No __ If yes, where/ _____
Automobile accident __ Yes __ No Work Related Accident __ Yes __ No Prior Treatment __ Y __ N
Describe how the injury occurred:

SYSTEM REVIEW - (PLEASE CHECK YES OR NO FOR EACH ITEM)

GENERAL SYMPTOMS

Good general health lately? ___ Yes ___ No

Height: _____ Weight: _____ Shoe Size: _____

EARS/NOSE/MOUTH/THROAT

Swollen glands in neck ___ Yes ___ No

Sore throat or mouth sores ___ Yes ___ No

Chronic sinus problems or rhinitis ___ Yes ___ No

GASTROINTESTINAL

Frequent diarrhea ___ Yes ___ No

Constipation ___ Yes ___ No

Blood in stool ___ Yes ___ No

Black tarry stool ___ Yes ___ No

Frequent heartburn/stomach upset ___ Yes ___ No

INTEGUMENTARY (SKIN)

Bleeding or bruising tendency ___ Yes ___ No

Change in a mole ___ Yes ___ No

MUSCULOSKELETAL

Joint pain ___ Yes ___ No

Joint stiffness ___ Yes ___ No

Weakness of muscles or joints ___ Yes ___ No

Back pain ___ Yes ___ No

NEUROLOGICAL

Frequent/recurring headaches ___ Yes ___ No

Light headed or dizzy ___ Yes ___ No

EMERGENCY CONTACT

Name: _____ Phone #: _____

Relationship: _____

CARDIOVASCULAR

Chest Pain ___ Yes ___ No

RESPIRATORY

Chronic /frequent coughs ___ Yes ___ No

Spitting up blood ___ Yes ___ No

Shortness of breath ___ Yes ___ No

PSYCHIATRIC

Depression ___ Yes ___ No

Claustrophobia ___ Yes ___ No

Anxiety ___ Yes ___ No

ENDOCRINE/HEPATIC

Excessive thirst/urination ___ Yes ___ No

Heat/cold intolerance ___ Yes ___ No

HEMATOLOGIC/LYMPHATIC

Easy bleeding/blood clotting ___ Yes ___ No

GENITOURINARY

Frequent urination ___ Yes ___ No

Blood in urine ___ Yes ___ No

Incontinence/dribbling ___ Yes ___ No

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PATIENT AUTHORIZATION

I hereby give Myers & Miller Podiatry, Inc. permission examine and treat my feet. I authorize Myers & Miller Podiatry, Inc. to submit any and all health care information to any health insurance program for their review and payment. I authorize payment of medical benefits to the practice. I further understand and agree to pay for services or amounts due to the physician even when the physician accepts assignment. These charges could include amounts applied to my annual deductible, co-payments, as well as charges denied by my insurance program or considered not medically necessary. Examples of these denied charges may include injections, routine medical care not due to an illness or condition and any other service specified in my health insurance contract.

Signature of patient (Parent or Guardian of Minor)

Date

MEDICARE BENEFICIARIES

I REQUEST THAT PAYMENTS MADE BY Medicare be payable on my behalf to Myers & Miller Podiatry, Inc. for any service(s) furnished to me by any of these physicians. I authorized any holder of medical information about me to be released to the Health Care Finance Administration and its agents of any information needed to determine these benefits payable to related services.

I understand my signature request that payment be made to Myers & Miller Podiatry, Inc. and authorizes release of medical information necessary to pay the claim. If the appropriate item of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer for agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the remaining amount between Medicare's payment and the Medicare allowed charge, any deductibles, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature

Date

Myers & Miller Podiatry, Inc.

Adam M. Myers, D.P.M.
Podiatrist

Andy W. Miller, D.P.M.
Podiatrist

December 4, 2009

To: All Patients

From: Dr. Myers and Dr. Miller

We are sure that you have heard about “identity theft”. As our practice continues to grow, it is one of our top priorities to keep our patients personal information safe. As a result we will need to review your insurance card at each visit.

We are sure that this inconvenience will be small in comparison to protecting your identity.

Thank you for your cooperation!

Patient's Name _____

Date _____

2010

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

If you have any questions about this notice, please contact our privacy officer:

Myers & Miller Podiatry, Inc.

Attn: Barbara Aubihl
515 Union Ave. Suite 147
Dover, Ohio 44622

1. Summary of Rights and Obligations Concerning Health Information

Myers & Miller Podiatry, Inc. is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Myers & Miller Podiatry, Inc.

Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We have ethical and legal obligations to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to;

- *plan your care and treatment;
- * provide treatment by us or others;
- *communicate with other providers such as referring physicians;
- *receive payment from you, your health plan, or your health insurer;
- *make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- *make you aware of services and treatments that may be of interest to you; and
- *comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have certain rights to your health information. You have the right to:

- *ensure the accuracy of your health record;
- *request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- *request an accounting of certain uses and disclosures of health information we have made about you.

We are required to;

- *maintain the privacy of your health information;
- *provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- *abide by the terms of our most current *Notice of Privacy Practices*;
- *notify you if we are unable to agree to a requested restriction; and
- *accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.

Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law.

We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices*. In the following pages, we explain our privacy practices and your rights to your health information in more detail.

2. We May Use or Disclose Your Medical Information In The Following Ways

- A. Treatment. We may use and disclose your medical information to provide you with medical treatment or services. For example, we may use your health information to write a prescription or to prescribe a course of treatment. We will record your current healthcare information in a record so, in future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.
- B. Payment. We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.
- C. Health Care Operations. We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcome in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.
- D. Medical Residents and Medical Students. Medical residents or medical students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.
- E. Business Associates. Myers & Miller Podiatry, Inc. sometimes contract with third-party business associates for services. Examples include answering services, transcriptionist, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associated to appropriately safeguard your information.
- F. Appointment Reminders. We may use and disclose information in your medical record to contact you as a reminder that you have an appointment at Myers & Miller Podiatry, Inc. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminder only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.
- G. Treatment options. We may use and disclose your health information in order to inform you of alternative treatments.
- H. Release to Family/Friends. Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- I. Health-Related Benefits and Services The following sentence is required only if the practice intends to send information to patients concerning health-related benefits or services. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face-to-face communications, such as appointments with your physician, we may tell you about other products and services that may be of interest to you.
- J. Newsletters and Other Communications. We may use your personal information in order to communicate to you via newsletters, mailings, or other means regarding treatment options, health related information disease-management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.
- K. Disaster Relief. We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- L. Marketing. In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value. Under no circumstances will we sell our patient list or your health information to a third party without your written authorization.
- M. Fundraising. We may contact you as part of a fundraising effort relating to the practice.
- N. Public Health Activities. We may disclose medical information about you for public health activities. These activities generally include the following:
- Licensing and certification carried out by public health authorities;
 - Prevention or control of disease, injury, or disability;
 - Reports of births and deaths;
 - Reports of child abuse or neglect;
 - Notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - Organ or tissue donation; and
 - Notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.
- O. Funeral Directors. We may disclose health information to funeral directors so that they may carry out their duties.
- P. Food and Drug Administration (FDA). We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.
- Q. Psychotherapy Notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health of safety, or as otherwise authorized by law.
- R. Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.
- S. Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- T. Law Enforcement. We may release your health information:
- *in response to a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law;
 - *to identify or locate a suspect, fugitive, material witness or similar person;
 - *about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
 - *about a death we believe may be the result of criminal conduct;
 - *about criminal conduct at MYERS & MILLER PODIATRY, INC.
 - *to coroners or medical examiners;
 - *in emergency circumstances to report a crime, the location of the crime or victims. Or the identity, description, or location of the person who committed the crime.
 - *to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law; and
 - *to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.
- U. D-Identified Information; we may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.
- V. Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.
- W. HLTV-III Test. If we perform the HLTV – III test on you (to determine if you have been exposed to HIV), we will not disclose the results of the test to anyone but you without your written consent unless otherwise required by law. We also will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.
- X. Limited Data Set; we may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. We may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

3. Authorization for Other Uses of Medical Information:

Uses of medical information not covered by our most current Notice of Privacy Practices or the laws that apply to us will be made only with your written authorization.

If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provide to you

4. Your Health Information Rights:

You have the following rights regarding medical information we gather about you:

- A. Right to Obtain a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.
- B. Right to Inspect and Copy: you have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this included medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the cost of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under Social Security Act (such as claims for Social Security, Supplemental Security Income, and MassHealth benefits) or any other state or federal needs-based benefit program.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor cost associated with transmitting the electronic health record.

- C. Right to Amend: if you feel that medical information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.

To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- *was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- *is not part of the medical information kept by or for Myers & Miller Podiatry, Inc.
- *is not part of the information which you would be permitted to inspect and copy, or
- *is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical records, but we may also include a rebuttal statement.

- D. Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your Health information make by us. In your accounting, we are not required to list certain disclosures, including:

*disclosures made for treatment, payment, and health care operation, purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years.

*disclosures made pursuant to your authorization

*disclosures made to create a limited data set;

*disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable cost of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

- E. Right to Request Restrictions; you have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purpose of payment or health care operations, and we are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.

Except as noted above, we are not required to agree to your request, if we do agree; we will comply with your request unless the restricted information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us;

*what information you want to limit;

*whether you want to limit our use, disclosure, or both; and

*to whom you want the limits to apply.

- F. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail.

To request confidential communications, you must make your request in writing to our privacy officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- G. Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

*a brief description of the breach, including the date of the breach and the date of its discovery, if known;

*a description of the type of Unsecured Protected Health Information involved in the breach;

*steps you should take to protect yourself from potential harm resulting from the breach;

*a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;

*contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask question or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

5. Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you know or should have known that the alleged violation occurred. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM:

I HEREBY ACKNOWLEDGE THAT ON _____ I RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM MYERS & MILLER PODIATRY, INC./ADAM M. MYERS D.P.M./ANDREW W. MILLER D.P.M. WHICH SET FORTH THE WAYS IN WHICH MY PERSONAL HEALTH INFORMATION MAY BE USED OR DISCLOSED BY MYERS & MILLER PODIATRY, INC./ADAM M. MYERS D.P.M./ANDREW W. MILLER D.P.M.: AND OUTLINES MY RIGHTS WITH RESPECT TO SUCH INFORMATION. BY SIGNING THIS ACKNOWLEDGEMENT FORM, I AGREE TO ALL OF THE TERMS AND CONDITIONS OF THIS POLICY AS STATED.

PATIENT'S SIGNATURE

DATE