

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.

Your Health Care Information - Protecting Your Privacy

It is your right as a patient to be informed of the privacy practices of your health care provider as well as to be informed of your privacy rights with respect to your personal health information. This Notice of Privacy Practices is intended to provide you with this information.

Greg Heal M.D.'s Responsibilities

It is your right as a patient to be informed of Greg Heal M.D.'s legal duties with respect to protection of the privacy of your personal health information.

Greg Heal M.D. is required to:

- Maintain the privacy of your health information;
- Provide you with a notice of the legal duties and privacy practices regarding protected health information collected and maintained about you; and
- Abide by the terms of this notice.

Greg Heal M.D. reserves the right to change the terms of the notice of privacy practices and make the new notice provisions effective for all protected health information that it maintains. Greg Heal M.D. also reserves the right change the terms of its notice with respect to any applicable more limited uses and disclosures.

Greg Heal M.D. will promptly revise and distribute its notice whenever Greg Heal M.D. makes a substantial change to any of its privacy practices.

Greg Heal M.D. will not use or disclose your health information without your authorization, except as described in this notice.

Your Health Information Rights

You have the right to:

- **Request a restriction on certain uses and disclosures of your health information.**

You have the right to request restrictions on certain uses and disclosures of protected health information, even if the restriction affects your treatment or Greg Heal M.D.'s payment or health care operation activities. However, Greg Heal M.D. is not required to agree to your requested restriction. For example, if you are an employee of the clinic and you receive health care services in the clinic, you may request that your health care record not be maintained in the general record filing area.

- **Receive Confidential Communications.**

You have the right to request that Greg Heal M.D. communicate your health information to you by alternative means or at alternative locations. Greg Heal M.D. shall accommodate reasonable requests. For example, you may request to be contacted at a phone number that is different from the phone number listed in your health care record.

- **Inspect and obtain a copy of your health record.**

You have the right to inspect and obtain a copy of your health care record. This request for access to your health care record must be submitted in writing to Greg Heal M.D.. This right may not apply to certain types of psychotherapy notes and Greg Heal M.D. may charge you a reasonable fee for a copy of your health care record. For example, you may request a copy of your health care record from your family physician.

- **Amend your health record.**

You have the right to request an amendment to your health care record if you believe your health information is incorrect or incomplete. You may be asked to make this request in writing and state the reason why your health record should be changed. If Greg Heal M.D. did not create the health information you believe is incorrect or if Greg Heal M.D. disagrees with you, Greg Heal M.D. may deny your request. For example, if you believe that information in your medical history is incorrect, such as your birth date, you may request that this information be amended.

- **Obtain an accounting of disclosures of your health information.**

You have the right to an accounting of disclosures of your health information that Greg Heal M.D. has made in compliance with state and federal law. The accounting will describe the dates of each disclosure, a brief description of information disclosed and the reason for disclosure. You will receive one accounting per year at no charge and Greg Heal M.D. may charge you a reasonable fee for each subsequent request. For example, you may request an accounting of disclosures made from your health record in the last year to the State for disease reporting.

- **Obtain a paper copy of the notice upon request.**

You have the right to obtain a paper copy of the notice upon request. For example, if you received the notice electronically, you may request that Greg Heal M.D. provide a paper copy of the notice.

Uses and Disclosures for Treatment, Payment and Health Care Operations

Greg Heal M.D. is permitted by the federal privacy rule to use or disclose your protected health information for treatment, payment or health care operations.

Greg Heal M.D. may use or disclose your health information for treatment.

Greg Heal M.D. may use or disclose your health information in the provision, coordination or management of your health care.

Example: Your information may be disclosed from one physician to another if they are consulting each other in relation to your care and treatment.

Example: Greg Heal M.D. may use your health information to provide you with an appointment reminder.

Example: Greg Heal M.D. may send you information about treatment alternatives or other health related services that may be of interest to you.

Greg Heal M.D. may use or disclose your health information for payment.

Greg Heal M.D. may use or disclose your health information to obtain reimbursement for the provision of health care services. The bill may include information that identifies you, your diagnosis and your treatment.

Example: Greg Heal M.D. may use or disclose your information to your insurer to obtain payment for the provision of health care services.

Greg Heal M.D. may use or disclose your health information for routine health care operations.

Greg Heal M.D. may use or disclose your health information for evaluation of patient care services, evaluating the performance of health care providers, activities relating to compliance with the law and business planning and development.

Example: Greg Heal M.D. may review your health record to determine the efficiency of the services provided to you in the emergency room.

Example: Greg Heal M.D. may contact you as part of a fundraising activity sponsored by your health care provider.

Uses or Disclosures of Your Protected Health Information Permitted Without Your Authorization

Without your written authorization, Greg Heal M.D. may use or disclose your health information for the following purposes:

As Required by Law: Greg Heal M.D. may use or disclose protected health information to the extent that the use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law. Uses or disclosures required by federal privacy rule and limited by the more protective requirements of state law include the following:

- Disclosures about victims of elderly or child abuse;
- Disclosures for judicial and administrative proceedings; or
- Disclosures for law enforcement purposes.

Public health: As required by law, Greg Heal M.D. may disclose your protected health information to the State of Wisconsin for the purpose of statutory reporting.

Greg Heal M.D. may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result to a state or federal public health agency for the purpose of preventing or controlling disease, injury or disability.

Greg Heal M.D. may disclose your protected health information excluding your HIV test result without your authorization to a county agency investigating child abuse.

Greg Heal M.D. may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result without your authorization to the Food and Drug Administration (FDA).

Greg Heal M.D. may disclose your HIV test result without your authorization to a person that may have sustained a contact that carries a potential for transmission of HIV.

Greg Heal M.D. may disclose your protected health information that is reasonably related to a work related illness or injury if an application for workers' compensation has been filed.

Victims of abuse, neglect or domestic violence: Greg Heal M.D. may disclose health information except for an HIV test result if Greg Heal M.D. reasonably believes that an individual is a victim of child or elderly abuse.

Health oversight activities: Greg Heal M.D. will not disclose HIV test results to health care oversight agencies without an authorization. Greg Heal M.D. may disclose your mental health, alcohol or drug abuse or developmental disability related health information to the Department of Health and Family Services, to the county for coordination of human services and to a representative of the board on aging and long-term care. The remainder of your protected health information may be disclosed without your authorization to a state or federal agency.

Judicial and Administrative Proceedings: Greg Heal M.D. may disclose your protected health information in response to a court order. Greg Heal M.D. may disclose your protected health information in response to a subpoena if Greg Heal M.D. is a party to a court action, Greg Heal M.D. has received your authorization to disclose and has not complied within two business days or Greg Heal M.D. failed to respond to a request for workers' compensation records. Greg Heal M.D. may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result in response to a subpoena from a state or federal agency.

Law enforcement: Greg Heal M.D. may disclose your protected health information except for HIV test results to county law enforcement officials for the reporting and investigation of elderly and/or child abuse. Greg Heal M.D. may disclose your protected health information except for mental health, alcohol or drug abuse or developmental disabled or HIV test results to state and federal law enforcement officials. Greg Heal M.D. may disclose mental health, alcohol or drug abuse or developmental disabled protected health information for limited law enforcement purposes as required by law. Greg Heal M.D. may disclose your protected health information to a law enforcement official in response to a court order.

For activities related to death:

Coroner or Medical Examiner: Greg Heal M.D. may use or disclose your protected health information that is not an HIV test result or related to mental health, alcohol or drug abuse and developmental disabilities to a coroner or medical examiner.

Funeral Director: Greg Heal M.D. may use or disclose your HIV test result a funeral director.

For cadaveric organ, eye or tissue donation purposes: Greg Heal M.D. may use or disclose your HIV test result to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Note: If you are a hospital, you may want to include the following language in your notice.

Greg Heal M.D. may use or disclose your HIV test result and protected health information that is not related to mental health, alcohol or drug abuse and developmental disabilities, to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research: Greg Heal M.D. may use or disclose your protected health information for research purposes if the researcher has obtained your permission or fulfilled the stringent privacy requirements of state and federal law.

To avoid a serious threat to health or safety: Greg Heal M.D. may disclose your protected health information under limited circumstances to law enforcement officials to avert a serious threat to health or safety.

Disclosures for specialized government functions: Greg Heal M.D. may disclose protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result for national security, for protection of the President and for medical suitability determination or of Armed Forces personnel to a state or federal agency.

Greg Heal M.D. may disclose protected health information to limited staff of a correctional institution or a custodial law enforcement official for the provision of health care and the transport of inmates.

Workers compensation: Greg Heal M.D. may disclose protected health information reasonably related to a workers' compensation injury.

Greg Heal M.D. has attempted to explain with this notice the circumstances where state law may be more protective than the federal privacy rule and provides greater privacy protection.

Except for the situations listed above and treatment, payment or health care operation purposes, the use or disclosure of your health information requires Greg Heal M.D. to obtain your written authorization. You may withdraw your authorization in writing at any time by submitting your written withdrawal to Greg Heal M.D.'s Privacy Officer.

Patient Complaint Process

If you believe your privacy rights have been violated, you may file a complaint with Greg Heal M.D. or with the Secretary of the Department of Health and Human Services. There will be no retaliation against you for filing a complaint.

To file a complaint with Greg Heal M.D. please contact the Greg Heal M.D.'s Privacy Officer who will provide you with the necessary assistance.

Questions or Concerns

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact:

Greg Heal M.D.
17050 W. North Ave.
Suite 103
Brookfield, WI 53005
262-786-6420

Effective Date: This Notice of Privacy Practice is effective as of [April 14, 2003].

Note: Insert your effective date if prior to the compliance date of the federal privacy rule.

Greg Heal M.D.

Summary Notice

I acknowledge that I have received from Greg Heal M.D. a written notice of Greg Heal M.D.'s privacy practices for protected health information. I acknowledge that the written notice contains a description of how medical information about me may be used and disclosed and how I may access this information. I acknowledge that the notice also contains:

- A description of the types of uses and disclosures that Greg Heal M.D. is permitted to make for treatment, payment or health care operations with and without my written authorization
- A description of each of the other purposes for which Greg Heal M.D. is permitted or required to use or disclose protected health information without my written authorization
- A description of uses or disclosures that may be limited or prohibited by law
- The description contains sufficient detail to make me aware of the uses or disclosures that are permitted or required by the federal privacy rule and other applicable law
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right
- A statement describing the Greg Heal M.D. duties under the federal privacy law
- A statement describing how I may express concern to the Greg Heal M.D. and the Secretary of the Department of Health and Human Services if I believe my privacy rights have been violated
- I have received information explaining how to contact Greg Heal M.D. for further information and the effective date which the notice is first in effect

Greg Heal M.D.

Written Acknowledgement of Receipt

I, _____, acknowledge that I have received the written
Patient Name
Notice of Privacy Practices from Greg Heal M.D..

[Patient or Personal Representative Signature]

[Date]

If Personal Representative, describe relationship

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained. Reason: _____

Employee Signature

Date

Greg Heal, M.D.
17000 W. North Avenue #105E
Brookfield, WI 53005

Patient Name _____ Date _____
Date of birth _____

Please list who you want to have access to your pertinent medical information?
(i.e. Family member, spouse, significant other)

May we leave a message on your answering machine? YES NO

Your preferred method of phone contact?

Home# Cell# Work#

EMERGENCY CONTACT NAME:

CONTACT PHONE#

GREG HEAL, M.D.

written acknowledgement of receipt

I, _____, acknowledge that I have received the written
Notice of Privacy Practices from Greg Heal, M.D.

(Patient or Personal Representative Signature)

(Date)

GREG HEAL, M.D.

Name _____ Date _____

No. of Preg.	Date of Birth	Length of Preg.	Birth Weight	Sex	Length of Labor	Complications
1						
2						
3						
4						
5						

Briefly list your complaints: _____

At what age did you start menstruating? _____

How long do your periods last? _____ How often do your periods occur? _____

Contraceptive use — past and present _____

About how many pads/tampons do you use during each menstrual period? _____

Do you bleed between periods? _____

First day of last menstrual period. _____

Date of last cancer smear. _____

List all operations you have had and approximate dates:

List all serious illnesses you have had and approximate dates:

List all medications you are taking:

Are you allergic to any medications? _____ Please List:

How many cigarettes do you smoke per day?

FATHER: Living Dead Age _____ MOTHER: Living Dead Age _____

Cause of Death _____ Cause of Death _____

How many brothers and sisters are living? _____ Are deceased? _____

List causes of death: _____

Does anyone in your family have diabetes, cancer, epilepsy, tuberculosis or heart disease? _____

Greg Heal, M.D.
Obstetrics • Gynecology

PATIENT INFORMATION *(Please Print)*

PATIENT'S NAME LAST FIRST MIDDLE INITIAL			HOME PHONE NO.	CELL PHONE	DATE OF BIRTH	AGE
STREET ADDRESS <input type="checkbox"/> PERM. <input type="checkbox"/> TEMP. (CHECK ONE)			SOCIAL SECURITY NO.		<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP MARITAL STATUS	
CITY	STATE	ZIP CODE	MAIDEN NAME		RELIGION (OPTIONAL)	
REFERRED TO OUR OFFICE BY:			OCCUPATION OF PATIENT (INDICATE IF A STUDENT) <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME			
PATIENT'S EMPLOYER					BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS			CITY	STATE	ZIP CODE	
NAME OF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT, IF MINOR (CHECK ONE)			OCCUPATION OF SPOUSE OR PARENT		WORK PHONE NO.	
BIRTH DATE:						
SPOUSE OR PARENT'S EMPLOYER				SOCIAL SECURITY NO.		
EMPLOYER'S STREET ADDRESS			CITY	STATE	ZIP CODE	
ADDRESS IF DIFFERENT FROM PATIENT:						

INSURANCE INFORMATION *(Please List in Order To Be Submitted)*

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
NAME OF POLICY HOLDER	NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
IDENTIFICATION NO.	IDENTIFICATION NO.	IDENTIFICATION NO.
GROUP NAME OR NO.	GROUP NAME OR NO.	GROUP NAME OR NO.
SPECIAL INSTRUCTIONS		
PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.

1. **PROFESSIONAL FEES:** Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary, average, median, etc. In many cases, the entire fee will be paid by an insurance company; while in other cases, an insurance company will pay only a portion of the fee. We will furnish a reasonable number of medical and disability insurance reports to expedite your insurance claims. It is customary to pay for services when rendered unless other advance arrangements have been made.
2. **FINANCIAL AGREEMENT:** I hereby authorize payment of medical insurance benefits due me (my dependent) to be made directly to Dr. Heal. I understand that I am responsible for that portion of fees not paid by insurance.
3. **RELEASE OF INFORMATION:** I authorize Dr. Heal to furnish insurance companies, or their representatives, information concerning my (my dependent's) illness, injury, and/or treatment necessary for completion of claims for insurance benefits.

Date

Signature of Patient, Parent or Guardian