Reset Form

Erik Gustke, M.D., PLLC

1201 Raleigh Road, Suite 204, Chapel Hill, N.C. 27517 Phone: 919-903-9470 Fax: 919-903-9475

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ ☐ Male ☐ Female ☐ _____

Date of Birth: _____ Age: _____ Relationship Status: _____ - _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (_____) _____

Employer and Position: _____ Work Phone: (_____) _____

E-mail address for communication from our office: _____ SS# _____ - _____ - _____

Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____

**How were you referred to Dr. Gustke: _____

Therapist: _____ PCP: _____

****Please Fill Out Attached Release of Information Form To Allow Communication Between Your Providers****

Person Responsible for Payment: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Responsible Party: _____ SS# _____ - _____ - _____ Date of Birth _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Email Address: _____

Employer and Position: _____ Work Phone: (_____) _____

Parent Information

Mother's Name: _____

Occupation: _____ Cell Phone: (_____) _____

Father's Name: _____

Occupation: _____ Cell Phone: (_____) _____

Briefly explain the difficulties that caused you to seek evaluation at this time: _____

_____

_____

How long has this problem been of concern to you? _____

When was this difficulty first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Please describe any major event that you feel might be related to the problem: _____

_____

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To Be Completed for Administrative and Billing Purposes:
(All requested information is REQUIRED to receive further care and/or appointments)

Person Responsible for Payment: _____ Relation to Patient: _____

Phone Number (Preferably Cell Phone): _____

E-Mail of Person Responsible for Payment: _____

I, _____ ,hereby authorize medical treatment by Erik Gustke, M.D. and agree to assume full responsibility for fees for these services.

Fees include regular scheduled appointments, phone calls lasting more than five minutes, medication refills outside of scheduled appointment time, letters, other paperwork, preauthorization of medications, missed appointments (per the office policy of 72 hour notification), returned checks, and time spent in collaboration with other health care providers or individuals within the circle of care. A current schedule of fees is available upon request.

I am aware that payment is due at the time of the appointment. Payment may be in the form of cash or check. Payment may also be in the form of credit card (Visa/ MasterCard/ Discover Card). I am aware that failure to pay at the time of the appointment in the form of cash or check will result in my credit card being charged the appropriate amount on the day of the scheduled appointment. Certain fees, such as those incurred from missed appointments and phoned in medication refills, will be charged using the credit card on file. I am aware that the signature below authorizes Erik Gustke, M.D. to keep my credit card and signature on file and to use the credit card for the above mentioned charges if necessary or directed to do so. I am aware that this form is valid and I authorize charges as necessary unless I cancel the authorization in written notice.

Credit Card Information Must be filled out completely unless special circumstances are discussed with Dr. Gustke

Credit Card Type (Please Circle): Visa MasterCard Discover Card

Card Holder's Name (As it appears on card): _____

Card Holder's BILLING Address w/ ZIPCODE: _____

Credit Card Number: _____

Expiration Date:_____ / _____ 3 Digit Code on Back of Card (CVA#): _____

Signature of Card Holder: _____ **Date:** _____

Should it become necessary, I authorize Erik Gustke, M.D. to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse. In addition, should it become necessary to need the services of a collection service or an attorney to secure payment, I am aware that I will be responsible for all costs, attorney fees, and other related expenses to the collection effort.

I have read this form completely and I am agreeing to the conditions set forth in this form and within the policies of the office of Erik Gustke, M.D.

_____ _____ / _____ / _____

Signature of Patient (and Parent if patient is a minor) **Date**

Erik Gustke, M.D., PLLC

1201 Raleigh Road, Suite 204, Chapel Hill, N.C. 27517 Phone: 919-903-9470 Fax: 919-903-9475

RELEASE OF INFORMATION: **Effective One year From (Today's Date): _____/_____/_____**

PATIENT NAME (Print): _____ DOB: _____/_____/_____

I AUTHORIZE DR. ERIK GUSTKE TO RELEASE INFORMATION TO and RECEIVE INFORMATION FROM:

THERAPIST: _____ Phone/Fax: _____

Address: _____

PRIMARY CARE: _____ Phone/Fax: _____

Address: _____

OTHER: _____ Phone/Fax: _____

Address: _____

INFORMATION THAT MAY BE RELEASED:

_____**Mental Health/Physical Information:** Which Includes: Presence and Progress in Treatment, Assessments, Diagnoses, Treatment Plans, Psychiatric Summary, Medication Records, Demographic Information
INITIALS

_____ **Drug and Alcohol Treatment:** Which Includes: Presence and Progress in Treatment, Assessments, Diagnoses, Treatment Plans, Psychiatric Summary, Medication Records, Demographic Information
INITIALS

_____ **Other:** _____
INITIALS

REASON: (☐) **Provide Continuity of Care** (☐) Personal Use (☐) Legal Purposes (☐) Social Security/Disability (☐) Insurance/Managed Care (☐) Other _____

DATES OF SERVICE: **(☐) ALL** **(☐) From** _____ **To** _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

1) review and understand the Notice of Privacy Practices;
2) this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
3) inspect and receive a copy of the material to be released;
4) request restrictions on how my health information is used and disclosed; and
5) receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that (agency) may not condition treatment on obtaining this consent/authorization from me.

_____ _____/_____/_____
Signature of Patient (and Parent if patient is a minor) **Date**

_____ _____/_____/_____
Witness Signature **Date**

Erik Gustke, M.D., PLLC

1201 Raleigh Road, Suite 204, Chapel Hill, N.C. 27517 Phone: 919-903-9470 Fax: 919-903-9475

E-Mail Authorization

I am signing this document to indicate that I authorize Dr. Erik Gustke to send me invoices and other confidential information by e-mail.

I understand that this means that the confidential information included in such e-mails is subject to the typical threats of confidentiality that exist with e-mail services and on the Internet. By using e-mail as a means to communicate confidential clinical information to Dr. Gustke, or his representative, via- statement, question, or request, I am implicitly authorizing Dr. Gustke, or his representative, to communicate confidential information in return and that the confidential information included in such e-mails is subject to the typical threats of confidentiality that exist with e-mail services and the Internet.

I am aware that Dr. Gustke's confidential voice mail- 919-903-9470, confidential fax- 919-903-9475 or the US Mail are always available as a means of confidential communication without the risks associated with the Internet. All questions, appointment scheduling, comments, medication refill requests, or other concerns may be initiated through the phone number -919-903-9470, or should be communicated directly.

_____ _____/_____/_____

Signature of Patient (and Parent if patient is a minor) **Date**

Notice of Privacy Practices Acknowledgement of Receipt

The Notice of Privacy Practices provides information about how protected health information about you may be used and disclosed.

In addition to the copy that has been provided for you, you may request additional copies from this office.

I acknowledge that I have received the Dr. Gustke's Office Policies, E-mail Authorization and Notice of Privacy Practices and am now responsible for knowing its contents.

_____ _____/_____/_____

Signature of Patient (and Parent if patient is a minor) **Date**

_____ _____

Print Name **Relationship**

Erik Gustke, M.D., PLLC

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Phone: 919-903-9470 Fax: 919-903-9475

It is **very important** that you read this information carefully.
Keep it for further reference as it provides important information related to treatment in my office.

This information is provided to acquaint you with my practice and to some of my routine office policies. Good communication is the foundation of effective care, so please let me know if you have questions or concerns about any matters relevant to treatment.

My practice is designed to provide outpatient services: evaluation, diagnosis, and appropriate treatment. The treatment approach utilized will depend on assessment of the particular difficulties you are experiencing. If it were to become necessary for you to be treated in a hospital setting, I would be available to continue with my outpatient treatment at the time of your discharge.

APPOINTMENTS

The nature of psychiatric care requires that my office visits be scheduled on an appointment basis. Session lengths are generally 50-70 minutes for intake, 45 - 50 minutes for therapy, 20-25 minutes for medication follow-up. My time is reserved for you. **Cancellations must occur at least 72 hours in advance to avoid incurrence of a charge.** Please understand that I will do absolutely everything possible to fill times that are cancelled less than 72 hours in advance, and if I am able to fill these times, you will not be responsible for the charge. If these times can not be filled due to the short notice, however, you will remain responsible for the full fee. **A charge will be made for missed appointments or late cancellations unless there are unusual circumstances.** If you have cancelled a regularly scheduled appointment time, I will assume that you intend to keep your next scheduled session unless you notify me otherwise.

TELEPHONE CALLS

I ask for your cooperation in helping me maintain my schedule. Telephone calls between sessions should be limited to matters of importance. I will do my best to return your calls in a prompt manner. However, sometimes it is not possible to call back at a specifically requested time. If, between sessions, a problem should arise which needs considerable discussion or attention, it may be necessary to schedule an office visit in order to have adequate time to deal with the matter. **Appropriate charges are made for extended telephone calls and consultations lasting more than 5 minutes.**

PRESCRIPTIONS

Any prescription you receive should last until our next scheduled appointment. **Prescriptions and refills should be obtained at the time of regularly scheduled office visits.** There may be a small fee applied for prescriptions needing to be called in outside of regular appointment hours. Before requesting a refill of your prescription between appointments, please check to be sure refills do not already exist so as to not incur a fee. If not obtained at scheduled appointment times, prescription refills should be requested at least one week prior to the time needed and may be requested by calling my office Monday through Thursday from 9:00 a.m. to 3:00 p.m. Time requirements necessitate that I not call in refills or authorize them directly to pharmacies except in unusual or emergent circumstances.

PAYMENT OF FEES

PAYMENT IN FULL MUST OCCUR AT THE TIME OF THE VISIT in the form of cash, check, or credit card (Visa, MasterCard, or Discover). The only exception to this policy is if other arrangements have been made with me personally. Payments may be given to the receptionist or to me before or after the session. Please feel free to discuss with me any questions or problems you have regarding the payment of fees for professional services. Also note that the credit card section of the "Payment Authorization" form **must** be filled out completely. Charges to your card will only occur if payment is not made at the time of the visit or if events related to out-of-appointment times occur.

Fees are incurred for regular scheduled appointments, phone calls lasting more than five minutes, medication refills outside of scheduled appointment time, requested letters or other paperwork, time spent with school officials or visits, preauthorization for medications, missed appointments (per the office policy of 72 hour notification), returned checks, and time spent in collaboration with other health care providers or individuals within the circle of care.

INSURANCE

Please remember that your insurance is to reimburse you directly for fees paid to the physician and is not a substitute for payment of fees for services provided. In most cases, your statement contains all the information needed for you to submit your insurance claim. Health insurance contracts vary considerably, and in most cases I am not able to advise you regarding the extent of your coverage or what specific services are covered by your insurance contract. While I may not be a panel provider on your insurance contract, many plans do reimburse for out-of-network providers. I suggest that you talk with your agent, carrier, or program representative to obtain the specific coverage information related to your contract. If I am asked to complete forms or contact managed care organizations for authorization purposes, it may, in some circumstances, be necessary to charge for time provided to the health care plan, and these charges will be assumed by the patient. If your insurance company does not make payment within 30 days from the time your claim is submitted, you should contact the carrier or agent to inquire about the delay.

AFTER HOURS AND EMERGENCY SITUATIONS

Non-emergent after hours messages may be left at my office number **919-903-9470**. I will usually get back to you in **1-2 business days**. When I am out of the office or not on-call, care for emergency situations will be provided by a competent colleague. **Only in cases of extreme urgency** am I available through the telephone number: 919-619-5224. **If for any reason during an emergency you are unable to reach myself or the physician on-call, or if you feel that your issue can not wait, you should go directly to the nearest emergency room for further evaluation and treatment.**

.....

I look forward to working with you or your family member and welcome your suggestions or comments about my practice.

Erik Gustke, M.D.

Erik Gustke, M.D., PLLC

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Phone: 919-903-9470 Fax: 919-903-9475

NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2014
This Notice was most recently revised on May 1, 2014

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

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT- Erik Gustke, M.D. at (919) 903-9470.

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

Protected Health Information is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

For Treatment. We may use Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose Protected Health Information to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose Protected Health Information so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give Protected Health Information to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies. Dr. Erik Gustke or a representative may contact me and leave a message via mail, e-mail, or via a phone call or to another alternative location any items that assist the practice in carrying out treatment, payment, and other health care operations. I have the right to request that Dr. Erik Gustke restrict how he uses or discloses my private health Information. His practice is not required to agree to my requested restrictions, but if he does, it is bound by this agreement.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you. Dr. Erik Gustke or a representative of Dr. Gustke may mail to my home, e-mail, or call my home or other alternative location and leave a message or in reference to any items that assist the practice in carrying out treatment, payment, and other health care operations, such as appointment reminders, insurance items and including calls pertaining to my clinical care, including laboratory test results, among others. I have the right to request that Dr. Erik Gustke restrict how he uses or discloses my private health Information. His practice is not required to agree to my requested restrictions, but if he does, it is bound by this agreement.

Minors. We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your Protected Health Information.

As Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclosure the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your Protected Health Information.

Military and Veterans. If you are a member of the armed forces, we may release Protected Health Information as required by military command authorities. We also may release Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves if you sue us.

Law Enforcement. We may release Protected Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and 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.

National Security. We may release Protected Health Information to authorized federal officials for national security activities authorized by law. For example, we may disclose Protected Health Information to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Newsletters and Other Communications. We may use your Protected Health Information to communicate to you by 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.

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 or safety, or as otherwise authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose Protected Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. But before we do that, we will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of Protected Health Information. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you

a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Security 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 breach of your Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days after we discover the breach. "Unsecured Protected Health Information" is Protected Health Information that has not been made unusable, unreadable, and undecipherable to unauthorized users. The notice will give you the following information:

- a short description of what happened, the date of the breach and the date it was discovered;
- the steps you should take to protect yourself from potential harm from the breach;
- the steps we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information where you can ask questions and get additional information.

If the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on our website or in a major print or broadcast media.

Right to Request Amendments. If you feel that Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request 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 (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (unless the disclosures were made through an electronic medical record, in which case you have the right to request an accounting of those disclosures that were made during the 3 years before your request), (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or 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 costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. Your must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at my website: www.EGustkeMD.com.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to Erik Gustke, M.D. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.