# Family PrimeCare LLC. / Solé Medical Spa
# 1489 Kennedy Road
# Tifton, Georgia 31794
# (229) 391-9931 / (229)238-2007

Date: _____

**Demographic Information:**

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Preferred Phone to use: Home ☐ Cell ☐ Work ☐

Is there any place you do **NOT** want me to leave a message? _____

Birth Date: _____ Male ☐ Female ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Social Security #: _____

Employer: _____ Occupation: _____

Employment Status: FT ☐ PT ☐ Not Employed ☐ Retired ☐ Disabled ☐ Student ☐

Email Address: _____

Would you like to Web Enabled so you always have Access to your Medical Records? Yes ☐ No ☐

**Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.**

Can Family PrimeCare /Solé Medical Spa send you educational/promotional materials such as newsletters via e-mail? Yes ☐ No ☐

Can Family PrimeCare/Solé Medical Spa discuss your private medical information with you via e-mail? Yes ☐ No ☐

**Emergency Contact Information:**

Emergency Contact: _____ Home #: _____ Work #: _____

Emergency Contact's Address: _____

Relationship to Patient: Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Grandparent ☐ Friend ☐ Other ☐

Is this Emergency Contact on your HIPAA Privacy Notice? Yes ☐ No ☐

**Guarantor Contact Information:**

Responsible Party Name: _____

Patient Relationship to Responsible Party: Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Employee ☐ Other ☐

Responsible Party's Phone: Home #: _____ Cell #: _____

Responsible Party's Social Security #: _____ Responsible Party's Birth Date: _____

Responsible Party's Employer: _____ Phone #: _____

Responsible Party's Employer's Address: _____

**Health Insurance Information:**

Primary Insurance Carrier: _____

Subscriber #: _____ Group # _____

Employer Providing Coverage: _____ Date Coverage Began: _____

Employee Name: _____ Employee Social Security #: _____

Employee Birth Date: _____ Employee Contact Phone #: _____

Patient Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Employee ☐ Other ☐

Secondary Insurance Carrier: _____

Subscriber #: _____ Group # _____

Employer Providing Coverage: _____ Date Coverage Began: _____

Employee Name: _____ Employee Social Security #: _____

Employee Birth Date: _____ Employee Contact Phone #: _____

Patient Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Employee ☐ Other ☐

**By signing below, I verify that the above information is correct and true to the best of my knowledge.**

**Signature of Patient** _____ **Today's Date**_____

# Family PrimeCare, LLC

Last Name: _____ First Name _____ Middle Initial _____ Chart # _____
Date: _____ Social Security # _____ Date Of Birth _____

## Medical History:

Diabetes..... Y N  Hypertension.....Y N  Heart Disease..... Y N
Stroke..... Y N  Cancer.....Y N  High Cholesterol..... Y N

| Previous Hospitalizations / Surgeries / Serious Injuries | Dates | Medications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Allergies: _____

## Social History:

Marital Status: Single____ Married____ Separated____ Divorced____ Widowed_____
Use of Alcohol: Never____ Rarely_____ Moderate____ Daily_____
Use of Tobacco: Never____ Quit_____(Year_____) Current Packs/day_____
Use Of Drugs: Never____ Past Use_____ Current Use_____ (Type/ Frequency_____)

## Family History:

| | Age | Diseases | If Deceased, Cause Of Death |
|---|---|---|---|
| Father | ____ | | |
| Mother | ____ | | |
| Siblings | ____ | | |
| | ____ | | |
| Children | ____ | | |
| | ____ | | |

## Do you have any of the following ?

Fatigue..... Y N  Loss of Appetite..... Y N  Dizziness..... Y N
Fever..... Y N  Nausea or Vomiting.... Y N  Seizures or Convulsions... Y N
Eye Problems..... Y N  Change in Bowels..... Y N  Tingling Sensations..... Y N
Ear Problems..... Y N  Blood in Stool..... Y N  Tremors..... Y N
Sinus Problems..... Y N  Abdominal Pain..... Y N  Memory Loss..... Y N
Sore Throat..... Y N  Heartburn..... Y N  Confusion..... Y N
Voice Change..... Y N  Painful Urination..... Y N  Nervousness..... Y N
Chest Pains..... Y N  Frequent Urination..... Y N  Depression..... Y N
Palpitations..... Y N  Blood in Urine..... Y N  Insomnia..... Y N
Shortness of Breath.... Y N  Loss of Urine..... Y N  Excessive Thirst..... Y N
Swelling..... Y N  Joint Pains..... Y N  Heat or Cold Intolerance . Y N
Coughing..... Y N  Joint Stiffness..... Y N  Dry Skin..... Y N
Wheezing..... Y N  Back Pain..... Y N  Easy Bruising..... Y N
Spitting up Blood..... Y N  Rash or Itching..... Y N  Bleeding Tendency Y N
Weight Loss..... Y N  Headaches..... Y N  Cold Extremities ..... Y N

Women:
Painful Periods..... Y N  Irregular Periods..... Y N  Vaginal Discharge..... Y N
Breast Pain..... Y N  Breast Lump..... Y N  Breast Discharge..... Y N
Last Menstrual Period _____  Last Pap Smear_____  #Pregnancies___ #Miscarriages___

Men:
Testicular Pain..... Y N  Straining to Urinate..... Y N  Impotence..... Y N

_____ _____ _____
signature  reviewed by  date

**RICHARD PIERZCHAJLO, M.D.**
*Clinical Assistant Professor of Family Medicine*
*School of Medicine, Mercer University*
*Board Certified*
*American Board Of Family Practice*
*doctor@fpcare.net*

Family PrimeCare, LLC

# Important Notice to Wellness Patients

*If you come in for your Wellness Visit and are seen for any problem other than Wellness, you will be charged for 2 visits and will be responsible for anything your insurance does not pay.*

*Labs may be ordered that may or not be covered under your wellness.*

*You will be responsible for anything your wellness does not cover.*

*One visit will be for your Wellness Exam and the other visit will for your Problem Visit*

Signature:_____

Date: _____

1489 KENNEDY ROAD • TIFTON, GEORGIA 31794 • 229-391-9931 • FAX 229-391-9961 • www.fpcare.net

**RICHARD PIERZCHAJLO, M.D.**
*Clinical Assistant Professor of Family Medicine*
*School of Medicine, Mercer University*
*Board Certified*
*American Board Of Family Practice*
*doctor@fpcare.net*

Family PrimeCare, LLC
"Our Family Caring For Your Family"

# Important Information for our Patients Regarding Annual Wellness Exams

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by Federal law and the American Medical Association (AMA). These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of Preventive and Screening services.

The Charges for Annual Well or Preventive Visit includes:

- Women – A complete history and exam and as needed, a breast, pelvic exam, and collection/preparation of pap smear specimen. The physician will ask questions about other medical conditions and discuss risk factors such as diet, exercise, stress management, sexually transmitted diseases, smoking cessation, self-breast exams, birth control, menopausal symptoms and hormone replacement therapy.
- Men – A complete history and exam and as needed, a prostate exam. The physician will ask questions about other medical conditions and discuss risk factors such as diet, exercise, stress management, smoking cessation, and sexually transmitted diseases.

The annual exam is preventive and the appointment is reserved for a preventive check-up. Discussions about problems and conditions for which you are already being treated that are under control are considered an integral part of the Wellness Visit.

If the purpose of your appointment is to discuss some health issues or problems that you are experiencing, you should make an appointment for evaluation or treatment of those problems, not an appointment for an annual exam. If you did not schedule your appropriate "problem visit," and then a separate problem is identified during the course of the Annual Exam, we will attempt to work with you in that same day if possible for your annual exam. Otherwise, you may need to reschedule your annual appointment for another time. We are required to submit our claims based on the documentation in the medical record of the service provided to you. If we see you for your annual exam and a problem visit on the same day, you will be charged for 2 separate visits. You will be responsible for anything your insurance does not cover. Additionally, we reserve the amount of time needed in the daily schedules for Annual Exams, Problem Visits, or Surgeries. The time scheduled for an Annual Exam does not allow adequate time to discuss or treat a "Problem Visit." Patients do not always realize that these are separate types of appointments on the daily schedules.

*OUR PROVIDERS CANNOT COMPLY WITH ANY REQUESTS TO IMPROPERLY ALTER THE MEDICAL RECORDS FOR THE PURPOSE OF OBTAINING PAYMENT BY BILLING AN ANNUAL EXAM AS "PROBLEM or SICK VISIT" WHEN NO OTHER MAJOR PROBLEMS WERE EVALUATED. SOMETIMES, PATIENTS WILL CLAIM THAT THEY WERE HERE FOR A PROBLEM, NOT AN ANNUAL, IN ORDER FOR INSURANCE TO COVER THE APPOINTMENT. ALSO, SOME PATIENTS EXPECT TO RECEIVE THE ANNUAL EXAM AND THE PROBLEM VISIT AT THE SAME SCHEDULED APPOINTMENT, BUT THESE ARE TWO SEPARATE TYPES OF APPOINTMENTS.*

While we regret that billing guidelines and insurance carriers may not pay for more of your annual exam, it is preventive by intent. You as the patient and insured will be responsible for payment as dictated by billing guidelines or your insurance plan for all co-payments and deductibles at the time of service.

Providing you with high quality healthcare remains our first priority. We thank you for choosing us to assist you with your healthcare needs.

Respectfully,
Family PrimeCare, LLC

| Printed Name of Patient | Signature of Patient | Date |
|---|---|---|

# Family PrimeCare LLC
## Financial Policy

1) **Unless prior arrangement is made, full payment is due at the time of service.** Your payment options are: cash, check, or credit/debit cards. We accept Visa, Master Card, Discover, or American Express. This payment may only be a co-pay, co-insurance or a deductible if you have medical insurance

2) Insurance Billing

- If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
- **You are responsible** for the bill, even though the insurance claim is filed by this office. Medical insurance is a contract between you and your insurance company. This office is not a party to that contract.
- **You are responsible** for all co-payments, deductibles and other adjustments made by your insurer(s) at the time of service.
- **If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.**
- Insurance companies may reimburse differently than the information they initially provide to us.
- If your insurance company does not make payment within 30 days, a statement of the balance due will be sent to you for payment.

3) Discounts for Self Pay Patients

We offer the following discounts. Only one discount may be applied to a bill.

- Time Of Service Discount - If you are a self pay patient and you are paying in full at the time of service, you will receive a 20% discount on medical services.

4) Missed Appointments/Late Cancellations

All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, **you will be charged $25 for the missed appointment.**

5) Past Due Accounts

**Accounts covered by insurance:** Arrangements for the balance remaining after insurance payment must be made within 30 days of the insurance payment.

- Balances of **$50 or less** must be made in **one payment**
- Balances of **$100 or less** must be made in **two payments**
- In extreme hardship, a payment plan may be arranged with the approval of the office administrator

**Accounts in default:** After 45 days or more of non-payment, accounts will be forwarded to an outside collection agency.

ese policies are subject to change without notice.
ve read, understood and agree to the policies described above:

ent or Responsible Party's Signature: _____ Date: _____

sed 9/23/2013

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST THAT OFFICE VISTS BE PAID AT THE TIME SERVICE IS RENDERED. WE WOULD RATHER CONTROL OUR BILLING COSTS THAN BE FORCED TO RAISE OUR FEES.

# FAMILY PRIMECARE, LLC

## CONSENT FOR TREATMENT

I authorize Family PrimeCare, LLC and the physician assigned to furnish the medical and/or surgical treatment or tests that are deemed appropriate by the physician for the patient whose name appears on this form.

## RELEASE OF INFORMATION

☐ Yes ☐ No — I authorize Family PrimeCare, LLC and all physicians to release any information, Reports, copies of records necessary to process insurance, etc., to other referral Physicians; my personal physician or attending physician; Blue Cross Blue Shield, Medicare, Medicaid, or other health insurance companies to complete the patient's claim(s); and the appropriate governmental agency of the United States as such information may be required by Federal Law.

## ASSIGNMENT OF INSURANCE BENEFITS

☐ Yes ☐ No — I hereby authorize and direct payment to Family PrimeCare, LLC and to all physicians of the benefits herein specified and otherwise payable to me. I understand I am financially responsible for the charges to all parties not covered by this assignment and/or third parties, etc.

## GUARANTEE OF ACCOUNT

☐ Yes ☐ No — I hereby guarantee payment of all charges incurred by the patient identified on this form.

☐ Yes ☐ No — I understand my charges will be billed to Worker's Compensation Carrier. I further understand should Worker's Compensation not pay, I will be responsible for all charges.

## OTHER CONSENTS

☐ Yes ☐ No — I understand that Family PrimeCare, LLC is a teaching office and observation and participation are necessary for the teaching purposes. I give my permission for students pursuing a regular course of study to observe and participate in any care or procedure under proper supervision, deemed proper in the education process.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Revised 7/2012

Dr. Richard Pierzchajlo
1489 Kennedy Road
Tifton, Georgia 31794

SOLÉ MEDICAL SPA

(229) 238-2007
Solemedspa.com
info@solemedspa.com

# Photograph Consent

For documentation purposes, Dr. Richard Pierzchajlo, requires before photographs to be taken. I understand that these photos are part of my confidential medical records. I have been informed of this policy.

Patient Name: _____

Patient Signature: _____

Date: _____

I also grant permission for Dr. Richard Pierzchajlo the unlimited use of my photographs for the following types of media including but not limited to the following:

- ☐ Print (Newspaper, Ads, and Events)
- ☐ Visual (New Patients)
- ☐ Facebook
- ☐ Internet

Patient Signature: _____

Date: _____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to the Patient (*If required*)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

**I give you permission to share my health information with:**

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

**Consent to email or text for appointment reminders and other healthcare communication.**

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

**The cell phone number I authorize** to receive text messages for appointment reminders and general health information is _____. Please initial _____.

**The email address that I authorize** to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via **text**.

_____ **I decline** to receive communications via **email**.

**Revocation** – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

***Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible***



*This form does not constitute legal advice and covers only federal, not state, law.*

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 26,2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, **Richard Pierzchajlo**. Information on contacting us can be found at the end of this Notice.

**We will keep your health information confidential, using it only for the following purposes:**

**Treatment:** While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

**Disclosure:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

**Right to an Accounting of Disclosures**: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $ 25.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

**Right to Request Restriction of PHI:** If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

**Required by Law**: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

**Fundraising:** We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

**Sale of PHI:** We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

**Appointment Reminders:** We may use your health records to remind you of recommended services, treatment or scheduled appointments.

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $25.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Breach Notification Requirements:** It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

## QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: **Family PrimeCare, LLC/Sole Medical Spa** Privacy Officer: **Richard Pierzchajlo**

Telephone: **(229) 391-9931** Fax: **(229) 391-9961**

Email: **rick@freindlycity.net**

Address: **1489 Kennedy Road, Tifton, Georgia 31794**