Internal Medicine & Pediatric Associates

Tony G. Karem, MD | Spencer R. Idstein, MD | Nicole B. Strecker, MD

New Patient Packet

Patient Demographic Information

Patient Name: _____ D.O.B: ____/____/_____

SSN: ____-____-_____ Gender: _____

Address: _____ State: _____ Zip Code: _____

Cell Phone Number: ____-____-_____ Home Phone Number: ____-____-_____

Email Address: _____

Insurance Information

Primary Insurance: _____ Member ID: _____

Group Number: _____ Guarantor: _____

Guarantor Address: _____ State: _____ Zip Code: _____

Guarantor D.O.B.: ____/____/_____ Relationship to Patient: _____

Guarantor Phone Number: ____-____-_____

Emergency Contact Information

Name: _____ Phone: ____-____-_____ Relationship: _____

Name: _____ Phone: ____-____-_____ Relationship: _____

Name: _____ Phone: ____-____-_____ Relationship: _____

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New Patient Health Questionnaire

Please print clearly and update your medical record by completing the following questionnaire.

Patient Name: _____ **Today's Date: _____**

Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced/ Separated ☐ Partnered

Medical Information

Do you have any major health concerns or questions that you would like to discuss with the doctor?

_____

_____

_____

Past Medical History *(Check all items that apply to you and fill in the blanks as needed)*

- ☐ allergies
- ☐ anemia or blood problems
- ☐ arthritis
- ☐ asthma
- ☐ blood transfusion, year_____
- ☐ cancer/tumor, type_____
- ☐ chickenpox, year_____
- ☐ COPD/emphysema
- ☐ diabetes
- ☐ drug or alcohol abuse
- ☐ epilepsy or seizure
- ☐ hearing loss
- ☐ other, specify_____
- ☐ heart disease or heart attack
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ high blood pressure
- ☐ kidney disease or stones
- ☐ ulcer disease or reflux
- ☐ depression/anxiety
- ☐ other mental illness
- ☐ sexually-transmitted disease
- ☐ skin disease, eczema, psoriasis
- ☐ stroke
- ☐ thyroid disease

Medical Information

_____

_____

_____

Medications *(List all medication with dosages, including over-the-counter medications and herbs.)*

_____

_____

_____

Health Questionnaire
New Patient

Patient Name: _____

Date of Birth: _____

Allergies

☐ No known drug allergies

Allergic to Drug:_____ Reaction: _____

Drug:_____ Reaction: _____

☐ No known food or environmental allergies (peanuts, bees, pollen, etc)

Allergic to Food/Other: _____ Reaction: _____

Food/Other: _____ Reaction: _____

Preventive Services (*Please list the date that you last had these tests or procedures.)*

Physical/Wellness Exam	☐ Never or Date _____
Pap Smear/Mammogram	☐ Never or Date _____
Colonoscopy	☐ Never or Date _____
Bone density or DEXA scan	☐ Never or Date _____
Cancer Screen	☐ Never or Date _____
Triple AAA (Abdominal Aortic Artery)	☐ Never or Date _____

Immunizations:

Tetanus/Tdap	Date _____	Influenza (Flu)	Date _____
Hepatitis A	Date _____	PneumoVax 23	Date _____
Hepatitis B	Date _____	Prevnar 13	Date _____
Chicken Pox	Date _____	Gardasil (HPV)	Date _____
Shingles	Date _____		

If you do not know your immunization history, please indicate the doctor or office that may have your immunization records:

Name: _____

Address: _____

Phone Number: _____

Risk Assessment/Social History

Do you currently smoke? ☐ Yes ☐ No If yes, packs per day ____ For how many years? _____

Did you smoke in the past? ☐ Yes ☐ No If yes, when did you quit? _____

Have you had exposure to smoke now or in the past? ☐ Yes ☐ No If yes, how many years? _____

Do you drink alcohol? ☐ Yes ☐ No How many alcoholic beverages do you have in a typical day? _____

Have you used illegal or recreational drugs in the past year? ☐ Yes ☐ No

Has anyone complained about your drug or alcohol use? ☐ Yes ☐ No

How many caffeinated beverages do you have per day? _____

Are you on a special diet (vegetarian, gluten free, etc)? ☐ Yes ☐ No If yes, specify: _____

Health Questionnaire
New Patient

Patient Name: _____

Date of Birth: _____

How many hours of sleep do you get on a typical night? _____

Do you exercise? ☐ Yes ☐ No If yes, what type, how often? _____

Do you wear helmets for sports (i.e. biking, lacrosse, skiing, etc.)? ☐ Yes ☐ No ☐ N/A

Do you use a seatbelt? ☐ Yes ☐ No

Do you have smoke detectors in your home? ☐ Yes ☐ No

Do you have carbon monoxide detectors in your home? ☐ Yes ☐ No

Are there firearms in your home? ☐ Yes ☐ No If yes, are they locked? ☐ Yes ☐ No

What is your gender identity? ☐ Female ☐ Male Other: _____

What is your preferred pronoun? ☐ He/him ☐ She/her ☐ They/them Other: _____

Describe your sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual Other: _____

Do you use contraception if you are sexually active? ☐ Yes ☐ No ☐ N/A

Do you practice safe sex if you are sexually active? ☐ Yes ☐ No ☐ N/A

Have you ever been a victim of abuse? ☐ Yes ☐ No When: _____

Have you been exposed to hazardous material? ☐ Yes ☐ No If yes, specify: _____

Have you often been bothered by feeling down, depressed, hopeless, or anxious? ☐ Yes ☐ No

Have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Do you have a Health Care Proxy? ☐ Yes ☐ No Do you have a Living Will? ☐ Yes ☐ No

With whom do you live? _____

Are you …. ?
- ☐ employed; type of employment _____
- ☐ stay at home
- ☐ retired
- ☐ full-time student: field of study _____
- ☐ disabled: reason/year _____
- ☐ other; specify _____

Do you have other Health Care Providers?		**Provider Name and address**
Dentist	☐ No ☐ Yes	_____
Eye doctor	☐ No ☐ Yes	_____
Mental health	☐ No ☐ Yes	_____
OB-GYN	☐ No ☐ Yes	_____
Other		_____

Health Questionnaire
New Patient

Patient Name: _____

Date of Birth: _____

Review of Systems *(Check any of the following that you have or have had in the past 6 months)*

Skin		**Neurologic**	
☐	Rashes	☐	Seizures
☐	Change in a wart or mole	☐	Paralysis
Ear nose and throat		☐	Numbness or tingling
☐	Nosebleeds	☐	Dizziness
☐	Allergies	☐	Balance problems
☐	Sinus problems	**Digestion**	
☐	Eye pain	☐	Heartburn or reflux
☐	Trouble seeing	☐	Ulcer
☐	Glaucoma	☐	Nausea/vomiting
☐	Double vision	☐	Diarrhea
☐	Ear pain	☐	Constipation
☐	Trouble hearing	☐	Abdominal pain
☐	Hoarseness	☐	Black or bloody stool
☐	Frequent sore throats	☐	Liver or gallbladder trouble
Respiratory		☐	Jaundice or yellow skin
☐	Shortness of breath	**Urinary**	
☐	Wheezing	☐	Pain on urination
☐	Cough	☐	Frequent urination
☐	Coughing blood	☐	Frequent urination at night
Cardiovascular		☐	Inability to hold urine
☐	Heart attack	☐	Blood and urine
☐	Chest pain	☐	Kidney stones
☐	Murmur	**Mental/emotional**	
☐	Irregular heartbeat/ palpitations	☐	Anxiety
☐	Swelling in ankles	☐	Depression
Endocrine		☐	Poor concentration
☐	Heat intolerance	☐	Poor memory
☐	Cold intolerance	**General**	
☐	Excessive thirst	☐	Poor sleep/insomnia
☐	Excessive urination	☐	Fatigue/low energy
☐	Hair loss	☐	Fever/chills
☐	Change in weight	☐	Poor appetite
Muscles/joints/bones		**Women only**	
☐	Joint pain	☐	Change in periods
☐	Muscle pain	☐	Vaginal itching or discharge
☐	Osteoporosis	☐	Breast lumps
☐	Joint swelling	☐	Bleeding after menopause
☐		**Men only**	
☐		☐	Testicular swelling
☐		☐	Change in urinary stream

Health Questionnaire
New Patient

Patient Name: _____

Date of Birth: _____

Family History *(Please check if applicable to relative, and leave blank if not applicable)*

Medical Condition	Father	Mother	Grandparent	Brother/Sister	Child
Alzheimer's or dementia	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Auto-immune disorders	☐	☐	☐	☐	☐
Blood disorders	☐	☐	☐	☐	☐
Cancer (specify type)	☐	☐	☐	☐	☐
Cholesterol (elevated)	☐	☐	☐	☐	☐
Depression/anxiety/mental illness	☐	☐	☐	☐	☐
Diabetes (specify Type 1 or 2)	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Obesity (20 pounds overweight)	☐	☐	☐	☐	☐
Pulmonary disease	☐	☐	☐	☐	☐
Stomach or intestinal disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Skin disease	☐	☐	☐	☐	☐
Thyroid problem	☐	☐	☐	☐	☐
Tumors	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
Current Age(s)or Age at death	☐	☐	☐	☐	☐

Thank you for taking the time to complete this form.

Internal Medicine & Pediatric Associates Office Use Only

Reviewed by: _____ Date: _____

Patient Name: _____

Date of Birth: _____

Internal Medicine & Pediatric Associates

Tony G. Karem, MD | Spencer R. Idstein, MD | Nicole B. Strecker, MD

Release of Personal Health Information

Please print clearly and complete the following information.

Patient Name: _____ **Today's Date: _____**

Date of Birth: _____

I authorize Internal Medicine & Pediatric Associates to release the following personal health information (please check the appropriate box).

- ☐ Lab Tests and Blood Work
- ☐ Imaging and Other Test Results
- ☐ Medication and Prescription Information
- ☐ Billing Information
- ☐ All Medical Records

The above personal health information may be released to the individual(s) listed below.

Name	Relationship	Date of Birth

I acknowledge and agree that I designated the above personal health information to be released to the individuals named above. I grant permission to Internal Medicine & Pediatric Associates to provide my designated personal health information to the individuals I named above. At any time upon request by an individual above, Internal Medicine & Pediatric Associates has my permission to provide my designated personal health information, verbally or in writing.

This permission is granted and remains in effect without time limit until I provide further written notice.

_____ _____

Patient Signature Signature Date

Patient Name: _____

Date of Birth: _____

Medical Records Request

Please print clearly and complete the following information.

Patient Name: _____ **Today's Date: _____**

Date of Birth: _____ **Phone Number: _____**

My Personal Health Information to be released (patient to designate below)

- ☐ Lab Tests and Blood Work
- ☐ Imaging and Other Test Results
- ☐ Medication and Prescription Information
- ☐ Entire Medical Record
- ☐ Progress Notes

Requesting Personal Health Information FROM:

Name of Facility/Provider _____

Street Address _____

City, State, and Zip Code _____

Phone _____ Fax _____

I authorize you to release my personal health information as designated above. When my information or medical records are used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Internal Medicine & Pediatric Associates has acted upon their reliance of my authorization. I understand this request is valid for one year from the date of signature if additional documents are needed in the future, unless I revoke my request in writing. My written revocation must be submitted to the Privacy Officer at Internal Medicine & Pediatric Associates at the above address.

_____ _____

Patient Signature Signature Date

Fax Medical Records (30 pages or less) to 502-241-5083.
Mail Medical Records over 30 pages to:
Internal Medicine & Pediatric Associates
7101 W. Highway 22
Crestwood, KY 40014
Phone: 502-241-6567

Internal Medicine & Pediatric Associates

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General Office and Financial Policies

The providers and staff at Internal Medicine & Pediatric Associates strive to provide affordable and high quality health care to pediatric and adult patients. We work hard daily to demonstrate the best in medical practice and to provide excellence in your treatment and care. We value our relationship with you, and advising you about our General Office and Financial Policies establishes good communication and helps us foster a open interaction regarding your comprehensive primary care.

Scheduling an appointment is setting a specific date and time that is uniquely reserved for you to visit one of our providers. Our providers value your time and work diligently to stay on schedule so that you can be seen at the time of your appointment. We make every effort to stay on time with you and all patients, and therefore we ask you to arrive five minutes early to check in and be ready for your scheduled appointment. All scheduled appointments are allowed a ten minute grace period that begins at the start of your appointment time. If you arrive after this ten minute grace period expires, then you will be considered as a no-show and subject to a No-Show Fee.

If you need to reschedule or cancel an appointment, please call us at least 24 hours before your scheduled appointment. **If you do not provide 24 hours advance notice, you will be considered as a no-show.** **Internal Medicine & Pediatric Associates reserves the right to charge you a No-Show Fee for any missed appointment or cancelled appointment with less than 24 hours notice.** The No-Show Fee, which is posted at the front desk, is billed to you and not billed to your insurance company. The No-Show Fee must be paid before you can be seen by your provider. Patients with three missed appointments could be asked to transfer their records to another doctor.

Upon registration we ask each patient or guardian to complete our Patient Registration Form. If you have health insurance, we will copy your active insurance card and valid driver's license. We wish to help you receive your maximum allowable insurance benefits, and to achieve this, we need your understanding of our financial policies and assistance to provide the necessary and appropriate information to file insurance claims on your behalf. Please keep us advised of your current and active health insurance.

Your health insurance is an agreement between you and your insurance carrier to pay for your medical care. Our office will file insurance claims as a courtesy to you, although it is your responsibility to understand the terms, conditions, and allowable benefits of your insurance plan, including co-payments, co-insurance, deductibles, and in-network vs. out-of-network provider participation. All allowed charges not covered by your insurance company are your responsibility, and as part of your agreement with your insurance company, you agree to pay allowed charges not covered by insurance to Internal Medicine & Pediatric Associates.

Although we may estimate what your insurance company might pay, your insurance company makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral or preauthorization, you are responsible for obtaining it. Failure to obtain the referral or preauthorization may lower the payment from the insurance company, which raises the amount you are responsible for paying.

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General Office and Financial Policies

Payment for services is due at the time services are rendered. We collect all co-pays and account balances at the time of your visit. **Your co-pay amount is set by your insurance company and must be paid at the time of visit.** This policy is set by your insurance company. If you cannot pay your co-payment on the date of service, you may be asked to reschedule your appointment. If you do not owe a co-payment, then we collect your account balance and co-insurance due. If you do not have health insurance, we collect the full amount owed, including account balance, at the time of service. We accept cash, checks, and credit cards.

Generally speaking, a statement is mailed to you monthly. You will not receive a statement on your account until your insurance company has met their obligation. A remaining balance or allowable amount not covered by your insurance becomes your obligation to pay Internal Medicine & Pediatric Associates. **When you receive a statement in the mail you will know that the balance owed is now your responsibility.** You may additionally receive a bill from the hospital, outpatient facility, or laboratory for hospital based procedures, x-rays, and lab work.

If you are a guardian or custodial parent, then you are responsible for full payment at the time services are rendered to pediatric patients. We will only bill the guardian or custodial parent as the guarantor and responsible party for the minor account. We are aware that patients and parents are sometimes involved in divorce and legal proceedings, but this is a private not a health care issue. Internal Medicine & Pediatric Associates will not become involved in family, marital, or legal disputes. **The guarantor is responsible for the account. If you have a question about this information, please ask to speak with our Office Manager.**

Your insurance company must pay your claim within forty-five (45) days of submission, but if your claim is not paid within 45 days, the responsibility of payment for the services rendered becomes yours. Should a significant delay in insurance payment occur, we may ask that you pay the bill directly to our office as we work with your insurance company to secure reimbursement to you There are some insurance companies for whom this would not apply. **If you are a subscriber to a plan that does not require our direct participation, then you will be responsible for the payment of any balance due. We collect all co-pays at the time of your visit. If you do not have a co-pay, then we will collect the appropriate co-insurance or balance due at the time services are rendered. Please inform our office of any change of insurance coverage at the time of your office visit.**

If your insurance company requires a referral, then as the subscriber, it is your responsibility to obtain a referral for any consultation, testing, x-ray, emergency care, or surgery required by your insurance plan. As your primary care provider, we will assist with obtaining the referral from your insurance company. If you seek care on your own from a specialist or consulting doctor, you must let us know 2 business days prior to your appointment with a specialist to request and process a referral from your insurance company. **Failure to obtain this referral prior to the date of service could allow your insurance company to deny (not pay) the claim.** In this event you will be responsible for the office visit and lab work. **If you go to an emergency room or immediate care center, please call our office within 48 hours of discharge so that your provider can follow up on your urgent visit.**

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General Office and Financial Policies

Forms and letters for FMLA, disability, and other purposes will be completed by providers or staff at Internal Medicine & Pediatric Associates for a fee, which is posted at the front desk. This fee will be collected at the time of the request and prior to the completion of the form or letter. Our providers and staff work very hard to provide the best care to all patients, including taking time outside of regular office hours to review charts and ensure forms and letters are filled out accurately. Forms, letters, immunization certificates, and other requests for medical records require five business days to complete.

Your physician will send your prescription to your pharmacy by the end of the day of your appointment. Providers often complete prescriptions at the end of the day after seeing all patients. If the work day is completed, please contact your pharmacy regarding the processing of your prescription. If the pharmacy has not received your urgent prescription, please call the on-call physician to request the submission of the prescription that evening. All clinical inquiries and messages will be reviewed and answered by the next business day.

We do not accept Workers Compensation insurance to pay for medical services rendered by Internal Medicine & Pediatric Associates. If you are involved in a motor vehicle accident, we do not submit claims to your health or car insurance company. Payment for services rendered must be paid at the time of your visit. We will provide you with an Encounter Form, which you can submit to your auto insurance company for reimbursement.

There is a fee, which is posted at the front desk, for any checks returned by the bank for insufficient funds.

If you have a balance on your account, we will send you a monthly statement showing the previous balance, any new charges to the account, any finance charge, and payments or credits applied to your account during the month. We will send statements for 3 months. After three months, you will be sent a letter. If you do not contact us after three statements and a letter, then your account could be sent to a collection agency and you will not be able to schedule or see the physician until your account is settled fully.

We understand that medical care can be costly, and we want you to feel comfortable discussing any financial difficulties with our office. Please contact our Office Manager or a billing representative to make payment arrangements to manage your account. We will always be willing to work with you on a payment plan as long as your intent to make payment is evident to us.

We hope that we have covered some of your questions about our office and financial policies. If you have other questions, please call the Office Manager, staff, or provider at Internal Medicine & Pediatric Associates.

This Agreement is between Internal Medicine & Pediatric Associates, PSC, as creditor, and the Patient/Debtor named on this form. In this agreement the words “I,” “my,” “you,” “your,” and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Internal Medicine & Pediatric Associates, PSC.

Internal Medicine & Pediatric Associates

Tony G. Karem, MD | Spencer R. Idstein, MD | Nicole B. Strecker, MD

General Office and Financial Policies

By executing this Agreement:

- I grant permission to the providers and staff at Internal Medicine & Pediatric Associates to release medical information for insurance filing, specialist referrals, and other purposes related to my primary care.
- I agree to pay for all services that are received.
- I have read and understand the above office and financial policies.
- I agree to all of the terms and conditions contained herein.
- The Agreement will be in force and effect on the date of my signature below.

Acknowledgment

Date of Birth

Printed Patient Name

Patient Signature

Signature Date

**Internal Medicine &
Pediatric Associates**

7101 W Highway 22
Crestwood, KY 40014
502-241-6567
www.impadocs.com

Your Information. Your Rights.

Our Responsibilities.

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 Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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

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

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Special Notes:

We do not create or manage a hospital directory.

We do not create or manage psychotherapy notes at Internal Medicine & Pediatric Associates.

Our Responsibilities

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

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

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

Effective Date of this Notice: July 1, 2019

This Notice of Privacy Practices applies to the following organizations.

Internal Medicine & Pediatric Associates is part of the Baptist Health Care Partners, LLC Accountable Care Organization. Some patient treatment information is shared with Baptist Hospitals in Louisville and Lagrange, Hardin Memorial Hospital in Elizabethtown, and Baptist Health Medical Group providers in the Greater Louisville area.

Privacy Official: Practice Administrator
502-241-6567
support@impadocs.com