vibrant health family clinic
KEN WARREN, APRN

REGISTRATION FORM

(Please Print)

Today's date:					PCP:	
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:			Home phone no.: ( )	
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Facebook ❑ Other						
Other family members seen here:						
Email Address:	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Declined				
BILLING AND INSURANCE INFORMATION						
Please give your insurance card to the receptionist.	❑ Check here if information is the same as patient					
Name of person responsible for bill:	Birth date: / /	Address (if different):		Home phone no. ( )		
Is this person a patient here? ❑ Yes ❑ No	Social Security no.:					
Responsible Party's Email Address:						
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No						
Insurance Company:	Insurance Co. Phone #:					
Subscriber ID (Policy #):	Group ID					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Effective Date: / /	Co-payment amount: $		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber ID (Policy #):	Group ID:			
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Street address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize VIBRANT HEALTH FAMILY CLINIC or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Vibrant Health Family Clinic APRN PC

All patients requesting the completion of forms must have these forms prepared and completed during an appointment. Forms requiring extensive documentation or test results will need to be completed and picked up after your appointment time. Your insurance company will NOT cover the cost of this service therefore; a fee of $50 must be paid at your appointment time. Examples of these forms are: FMLA, Short Term Disability, school, and pre-employment evaluation forms. These forms require careful completion and review by our Provider. Please do not ask Vibrant Health to verify medical eligibility/status without an appointment. We appreciate your patience and understanding with this policy.

I understand the above policy.

Patient Signature _____ Date _____

vibrant health family clinic
KEN WARREN, APRN

HEALTH HISTORY QUESTIONNAIRE

Patient's Name:	Date of Birth: / /	Gender: ❑ M ❑ F

MEDICATIONS

List all prescriptions and over-the-counter medications, herbs and vitamins you take on a regular basis.

Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:

ALLERGIES

List the names of any medication, food or environmental allergies and your reactions.

Name:	Reaction:
Name:	Reaction:
Name:	Reaction:

MEDICAL HISTORY

Check the items that apply to you.

❑ No Medical Problems	❑ Abnormal pap	❑ Alcohol/substance abuse	❑ Allergies / Hay Fever	❑ Asthma
❑ Bleeding Disorder	❑ Blood Clot	❑ Cancer	❑ Diabetes or Abnormal Blood Sugar	❑ Headaches
❑ Heart Disease or other Heart Problems	❑ Hepatitis or Other Liver Problem	❑ High Blood Pressure	❑ Intestinal Problems	❑ Migraine
❑ Psychological Problems	❑ Seizures	❑ Sexually Transmitted Disease	❑ Skin Disorder	❑ Thyroid Disorder
❑ TB / Tuberculosis	❑ Ulcer	❑ Urinary Tract Problems	❑ Other:	

SURGICAL, HOSPITALIZATION AND TRAUMA HISTORY

Check the items that apply to you.

❑ None	❑ Appendectomy	❑ Back Surgery	❑ Brain Surgery	❑ Cholecystecomy
❑ C-Section	❑ Eye Surgery	❑ Fusion of back or neck	❑ Hernia Surgery	❑ Heart surgery, cath or stenting
❑ Hip Surgery	❑ Hysterectomy	❑ Knee Surgery	❑ Lung Surgery	❑ Surgery to wrist or hand
❑ Prostate Surgery	❑ Shoulder Surgery	❑ Spine Surgery	❑ Tonsilectomy	❑ Surgery to bowel, spleen or other internal organ
❑ Tubal Ligation	❑ Vascular Surgery	❑ Vasectomy	❑ Mastectomy	❑ Other:

FAMILY HEALTH HISTORY

Check the items that apply to you.

FATHER'S SIDE:

❑ None	❑ Alcoholism	❑ Asthma	❑ Bleeding Disorders	❑ Blood cloths
❑ Dementia / Alzheimer's	❑ Diabetes	❑ Drug Addiction	❑ Heart Disease	❑ High Blood Pressure
❑ Psychological or Psychiatric Problems	❑ Rheumatoid Arthritis or other Autoimmune Disease	❑ Stroke	❑ Other:	

MOTHER'S SIDE:

❑ None	❑ Alcoholism	❑ Asthma	❑ Bleeding Disorders	❑ Blood cloths
❑ Dementia / Alzheimer's	❑ Diabetes	❑ Drug Addiction	❑ Heart Disease	❑ High Blood Pressure
❑ Psychological or Psychiatric Problems	❑ Rheumatoid Arthritis or other Autoimmune Disease	❑ Stroke	❑ Other:	

SOCIAL HISTORY

Complete the items that apply to you.

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other:

Number of Children:		Ages of Children:		Highest Education Level Completed: ❑ Current student (minor child) ❑ Completed 7th-11th Grade ❑ High school Diploma ❑ GED ❑ Some College ❑ Associates Degree ❑ Bachelor's Degree ❑ Graduate Degree

Are you sexually active? ❑ Yes ❑ No	Birth Control Method: ❑ Birth Control Pill ❑ Condoms ❑ IUD ❑ Depo Provera ❑ Other:
Have you ever smoked? ❑ Yes ❑ No	If yes, complete/check all that apply: ❑ Smoke _____ cigarettes per day ❑ Use smokeless tobacco ❑ No longer smoke but smoked _____ cigarettes per day for ____ yrs ❑ Cigarettes/Cigar/pipe smoked inside the house
Alcohol Use: ❑ None ❑ Occasional: _____ drinks per week ❑ Daily: _____ drinks per day	Recreational Drug Use: ❑ Never used ❑ Used drugs in the past: _____ ❑ Use drugs currently: _____
Exercise Habits: ❑ Never exercise ❑ Occasional exercise: ____ hours per week ❑ Regular exercise: _____ hours per week	Type of exercise: ❑ Running ❑ Walking ❑ Bicycling ❑ Aerobics ❑ Weight Lifting ❑ Yoga ❑ Other: _____

List your recent travel locations outside the United States: _____

REVIEW OF SYSTEMS

Check the items that apply to you.

GENERAL SYMPTOMS: ❑ None ❑ Fever ❑ Fatigue ❑ Unusual weight change ❑ Other:

HEAD: ❑ None ❑ Frequent headaches ❑ Pain jaw with chewing ❑ Facial pain or numbness ❑ Other:

EYES: ❑ None ❑ Vision changes ❑ Eye pain ❑ Double vision ❑ Other:

EARS: ❑ None ❑ Hearing loss ❑ Ringing in ears ❑ Other:

NOSE: ❑ None ❑ Change in smell ❑ Postnasal drainage ❑ Sinus problems ❑ Other:

THROAT & MOUTH: ❑ None ❑ Voice Changes ❑ Taste Disturbances ❑ Mouth sores ❑ Dental problems ❑ Other:

CARDIOVASCULAR: ❑ None ❑ Chest pain ❑ Palpitations ❑ Swelling in ankles/feet ❑ Pain in legs with walking ❑ Other:

RESPIRATORY: ❑ None ❑ Wheezing ❑ Prolonged cough ❑ Night sweats ❑ Coughing up blood ❑ Abnormal chest x-ray ❑ Other:

GASTROINTESTINAL: ❑ None ❑ Difficulty swallowing ❑ Abdominal pain ❑ Blood in stools ❑ Change in bowel habits ❑ Incontinence ❑ Other:

GENITOURINARY: ❑ None ❑ Painful urination ❑ Urgency ❑ Frequency ❑ Blood in urine ❑ Prostate problems ❑ Change in urine stream ❑ Impotence ❑ Other:

MUSCULOSKELETAL: ❑ None ❑ Join stiffness ❑ Joint pain ❑ Bone deformities ❑ Muscle pain ❑ Back pain ❑ Other:

SKIN/HAIR/NAILS: ❑ None ❑ Rashes ❑ New or changing skin lesions ❑ Persistent rash ❑ Unwanted hair growth ❑ Hair problems ❑ Other:

NEUROLOGIC: ❑ None ❑ Frequent headaches ❑ Insomnia ❑ Dizziness or imbalance ❑ Numbness ❑ Fainting ❑ Uncontrolled movements ❑ Episodic vision loss ❑ Other:

PSYCHIATRIC HISTORY: ❑ None ❑ Depression ❑ Anxiety ❑ Irritability ❑ Recurrent bad thoughts ❑ Hallucinations ❑ Other:

ENDOCRINE: ❑ None ❑ Intolerance to heat or cold ❑ Changes in sex drive ❑ Menstrual problems ❑ Other:

BLOOD: ❑ None ❑ Easy bleeding or bruising ❑ Anemia ❑ Other:

LYMPH: ❑ None ❑ Unexplained swollen areas ❑ Other:

ALLERGIC / IMMUNOLOGIC: ❑ None ❑ Seasonal allergies ❑ Hay fever symptoms ❑ Itching ❑ Frequent Infections ❑ Other:

CONSENT FOR MEDICAL TREATMENT

I am the patient or the patient's duly authorized representative. I do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatment regimens deemed necessary by my Provider, for myself, or the patient for whom I am responsible. I am aware that the practice of medicine is not an exact science and I do acknowledge that there have been no guarantees made to me as a result of treatment or performed examinations. I have read this form completely, have had the opportunity to ask questions, and have been fully informed as to the contents of this agreement. I hereby authorize the release of medical infom1ation necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Vibrant Health Family Clinic.

_____ _____

Patient/Guardian Signature Date

OFFICE / FINANCIAL POLICIES

1. **Appointment Scheduling**
   All new patients will need to complete the new patient packet completely before being seen as a patient. Due to scheduling constraints, we cannot guarantee same day appointments but do our best to provide work-in appointments on an as needed basis for ill patients. Those with scheduled appointments will be seen ahead of work-ins. However, medical care can be unpredictable and patient needs are not neglected, therefore, unseen delays may occur. **PLEASE NOTE: We require a minimum of 24 hours notification of canceling an appointment. Otherwise, a no-show will be documented on the patient's medical record. If you are more than 10 minutes late to your visit (without a phone call letting us know), you will not be seen and it will considered a No Show appointment.**
2. **Insurance**
   We accept most insurance plans but please ask since this can change over time. If we do not accept your insurance, payment is due in full at each visit before you can be seen. We must obtain a copy of your driver's license and current valid insurance card in order to verify your insurance plan. This information will be validated at each appointment and if your insurance changes please notify us immediately. Please contact your insurance company with any questions regarding covered or non-covered procedures, tests, labs, medications or any other medically necessary recommendations. **Co-Pays are required to be paid PRIOR to being seen for your visit. If your insurance company does not pay your claim entirely, it is your responsibility to make payment.**
3. **Cash Payments**
   We accept patients on a cash basis. All payments must be made prior to being seen. We accept payment in cash or credit card.
   - *New Patient Visits: $140*
   - *Patient Visit: $90*
   - *Well Child Visit: $80*
   - *Sports Physicals: $50*
   - *Lab Draw Fee: $25*
   - *Lab Fees: Varies depending on the laboratory procedure*
4. **Canceling Appointments / No Shows**
   If you cannot attend your appointment, we require a 24-hour notice so that the appointment can be made available for one of our patients. Please call the office as soon as you know you will not be able to make it. Appointments not cancelled 24 hours in advance will be considered a "No Show" appointment. **If a patient accumulates 2 No Show appointments, the patient will only be allowed to make SAME DAY appointments and can also result in dismissal from our clinic.**
5. **Medication Refills**
   All medication refills require a follow-up visit within 1 - 3 months with accompanying lab work. This includes routine prescriptions for chronic medications. All medications have the potential to affect your liver, kidneys, and other body systems. Routine follow-up with lab work allows our Provider to monitor your progress. Please bring all bottles prescribed by all of your Providers with you to your appointments. This decreases the chance of duplicate refills and dangerous drug interactions. **We will NOT HONOR PHONE CALL REQUESTS FOR MEDICATION REFILLS**. All controlled medications require an in-office urine drug screen and pill count to be performed during the refill visit.
6. **Medical Records**
   All of our patient medical records are kept confidential. By law, we are required to keep the original medical record in our possession for 7 years. Copies may be furnished to you when you request them in writing. Our policy requires 7-day notice for the preparation of copies. Charges are in accordance with the state law Chapter 64B8-10.003 that states the following: *"Reasonable costs may not be more than $1 per page for the first 25 pages and $0.25 for every page thereafter."* Copies are provided for free to the provider of your choice upon transfer from the practice and also to a specialist for continuity of care.
7. **Referral Orders**
   As a Primary Care Provider, we offer referrals to specialists. These referrals take a lot of time and attention from our staff to prepare and track. If you do not keep your appointment for your referrals that were prepared by our office, we will limit future referral orders to 1 per visit.
8. **Pain Management**
   Chronic pain management is NOT provided at Vibrant Health Family Clinic. In certain cases where a patient is awaiting work-up of a surgical problem or acceptance to pain management, prescriptions may be given for 1-2 months. There are NO REPLACEMENT PRESCRIPTIONS GIVEN WITHOUT A POLICE REPORT. Dismissal from a pain medication clinic could result in dismissal from this clinic and/or the cessation of controlled prescription medication. No further referrals for pain management will be made.
9. **Controlled Substances**
   - **Controlled medications will only be refilled monthly with an appointment.**
   - All schedule 3 and 4 medications will be written for only 1 month at a time. Every month, patients will need to be seen IN THE OFFICE. This includes, but is not limited to, the following: All forms of pain medications, most muscle relaxers, most sleeping agents (Ambien, Zolpidem, Lunesta), all benzodiazepines (Klonopin/Clonazepam, Restoril/Temazepam, Serax/Oxazepam, Zanax/Alprazolam), Codeine Preparations (Tylenol #3, Tussionex), Testosterone Replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate).
   - Patients may be tested at every appointment and any inconsistent findings could result as a patient from this clinic.
   - We do not prescribe any stimulant medications (such as Concerta, Ritalin, Adderall, Dextroamphetamine, Vyvanse) for adults or children diagnosed with ADD/ADHD. We will recommend that you return to the psychiatrist that originally made that diagnoses. If that is not possible, we will gladly provide you with recommendations for local psychiatrists to assist with this. Non-controlled medications (such as Strattera) may be managed at this office.
   - Obtaining a controlled medication from any other provider, with the exception of a referring provider, could result in a dismissal from this clinic.

_____ _____
PATIENT NAME PATIENT'S DATE OF BIRTH

_____ _____
PATIENT / GUARDIAN SIGNATURE TODAY'S DATE

Ken Warren, APRN
1822 E 15th Street, Suite A, Tulsa, OK 74104
PH: (918) 591-3567 | FAX: (918) 591-3568

MEDICAL HOME AGREEMENT

This Medical Home Agreement Concept is an agreement between you and your provider to meet all of your healthcare needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Respect your rights as a patient. Treat you with dignity.
2. Focus on listening to your concerns. Educate you on your health care. Provide and track preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with quality and safe health care.
5. Work to schedule office appointments in a timely manner.
6. Be available to you 24 hours a day, by appointment, phone calls and/or electronic communication.
7. Provide you with other healthcare resources when we are unavailable.
8. Provide you with referrals to specialist it determined medically necessary.
9. Provide you with treatment, medications, equipment and any other resources if determined medically necessary.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your PCP, to meet a// of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report any changes related to your health, treatments, medications, etc. This includes use of all medications, prescribed, over-the counter, herbal and/or street drugs. This also includes any medical equipment being used, ordered or recommended.
4. Call us before going to the Emergency Room, unless it is life threatening.
5. Notify us after any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule all medical appointments in a timely manner.
7. Keep appointments as scheduled with us and any specialists.
8. If you cannot keep an appointment call before your appointment time to cancel or reschedule.
9. You may be dismissed from your PCP panel if you repeatedly miss appointments without notice.

YOUR HEALTHCARE IS A TEAM APPROACH INVOLVING BOTH YOU AND YOUR PROVIDER!

_____ _____
Patient/Guardian Signature Date

_____ _____
Healthcare Provider Date

Ken Warren, APRN
1822 E 15th Street, Suite A, Tulsa, OK 74104
PH: (918) 591-3567 | FAX: (918) 591-3568

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME:	Date of Birth:
Previous Name:	Social Security #:

I request and authorize _____ to release healthcare information of the patient named above to **VIBRANT HEALTH FAMILY CLINIC, APRN, PC at 1822 East 15th Street, Ste 1, Tulsa, OK 74104** at Phone Number (918) 591-3567 and Fax Number (918) 591-3568.

The request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition or dates:

❑ All healthcare information

❑ Other:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non -specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❑ Yes ❑ No	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
❑ Yes ❑ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

_____ _____
Patient/Guardian Signature Date

vibrant health family clinic
KEN WARREN, APRN

Ken Warren, APRN
1822 E 15th Street, Suite A, Tulsa, OK 74104
PH: (918) 591-3567 | FAX: (918) 591-3568

AUTHORIZATION

PATIENT'S NAME:	Date of Birth:

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the health care providers. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the healthcare providers to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to cart by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____
Patient/Guardian Signature Date

I authorize this facility to release information to (Please check all that apply):

❑ Spouse: List complete name of spouse _____

❑ Children: List complete names/phone # of children _____

❑ Other: List complete names/phone # _____

_____ _____
Patient/Guardian Signature Date

MEDICARE PATIENTS

I request that payment of authorized Medicare (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me: to release Medigap Insurer _____ any information needed to determine those benefits payable for related services.

_____ _____
Patient/Guardian Signature Date

MEDICARE LIFETIME AUTHORIZATION
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize, any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf. I assign the benefits payable for healthcare provider services to the healthcare provider or organization furnishing the services or authorized such nurse practitioner or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Name Title or Relationship

_____ _____
Witnessed by Address

vibrant health family clinic
KEN WARREN, APRN

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY VIBRANT HEALTH FAMILY CLINIC AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

REQUIRED USES AND DISCLOSURES

By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTH CARE OPERATIONS AND OVERSIGHT

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's/nurse practitioner's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes Updated 01.28.15 / asw
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. 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. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable 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 of federal needs-based benefit program.

NOTICE OF PRIVACY PRACTICES

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request. You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (918) 591-3567. Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY RIGHTS

By signing below, I hereby acknowledge receipt, on this date, of the Notice of Privacy Rights, under the provisions of the Health Insurance Portability and Accountability Act: (“HIPAA”). Vibrant Health Family Clinic has provided this document to me.

I have been advised that except for evaluation and treatment, payment matters and clinic operations, under HIPAA, protected health information will not be disclosed without my written authorization.

_____ _____

Patient/Guardian Signature Date

_____ _____

Print Name Patient’s Name (if different than signature)