NorthStar
MEDICAL SPECIALISTS

SLEEP DISORDERS CENTER

MEDICAL & SURGICAL WEIGHT MANAGEMENT

PULMONARY REHABILITATION

1345 King Street
Bellingham, WA 98229-6223
T: (360) 676-1696
F: (360) 676-6636
www.northstarmedicalspecialists.com

Informed Consent for Services

I, _____ authorize Dr. Anthony Burden at NorthStar Medical Specialists and whomever they designate as their assistants, to help me in my weight reduction efforts.

I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I have the option of choosing to use prescription appetite suppression. Risks of prescription of appetite suppression may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

Insurance Consent: I request that payment of authorized benefits be made to NorthStar Medical Specialists and the facility's participating physicians for any services furnished to me. I authorize this facility to release to Medicare and/or accident or health insurer, medical or financial information as needed for claims processing, fraud investigation or quality of care review and studies. I understand that I may revoke this consent for release of information at any time by notifying the facility in writing, but such revocation will not apply to information previously released.

Grievance procedure: I acknowledge that the Operations Director and Medical Director make themselves readily available to discuss my concerns or questions I may have. I acknowledge that if I have a grievance of any kind, I have the right to utilize the Section 504 Grievance Procedure, posted in the facility lobby.

I have read and fully understand NorthStar Medical Specialists' Informed Consent for Services

_____ _____ _____

Patient Signature (or legal representative) Relationship to patient Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)

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Patient Registration

Patient's full name:_____ Social Security Number:_____

Mailing Address:_____Apt#:____ Birthdate:___/__/___

City/State/Zip:_____ Email: _____

Home Phone#:_____ Work Phone#:_____ Sex:_____ Age:_____

Language: _____ Race: _____ Ethnicity: _____

In case of emergency, contact:_____Phone#:_____

Relationship to patient: _____ Spouse's Employer: _____

Referring physician:_____Primary care physician:_____

Reason for referral: _____

How did you hear about NorthStar Medical? (circle one below)

Doctor referral / Friend/family referral / Newspaper / Radio / Other _____

Name of Primary Insurance Company:_____

Subscriber's name:_____ Date of Birth:_____

Subscriber's relationship to patient:_____

Subscriber's #:_____ Group #:_____

Name of Secondary Insurance Company:_____

Subscriber's name:_____Date of Birth:_____

Subscriber's relationship to patient:_____

Subscriber's #:_____ Group #:_____

Social History

Occupation: _____Employer: _____

Shift worker? □Yes □ No What shift? _____

Work status: □Full-time □Part-time □Retired □Unemployed □Self-employed □Disabled □Student

Marital status: □ Single □ Married □ Widowed □ Divorced □ Partner

Steady Partner? □Yes □ No

Number of Children: _____

Do you live alone or with others? □ Alone □ With others

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Smoking Status: □ Never □ Former smoker □ Current smoker □ Current someday smoker
□ Current smoker – Status Unknown □ Unknown

Smoking – How much? □ 1 PPW □ 2 PPW □ ¼ PPD □ ½ PPD
□ 1 ½ PPD □ 2 PPD □ 3+ PPD Has smoked since: _____

Chewing tobacco: □ None □ 1/day □ 2-4/day □ 5+/day

Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy

Alcohol years of use: _____

Illicit drug use: _____

Family History

- ☐ Alcohol/Substance abuse
- ☐ Alzheimer's Disease
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ CAD
- ☐ Cancer
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Restless Legs Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stoke

Other: _____

Past Medical History

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ Cardiac arrhythmias
- ☐ Cardiomegaly
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes

- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gerd/Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Head injury
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Polycystic Ovarian Disease
- ☐ Pulmonary Embolism
- ☐ Restless Leg Syndrome
- ☐ Snoring
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vitamin D Deficiency

Other: _____

Surgical History

- ☐ Adenoid Surgery
- ☐ Amputation
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopic Surgery
- ☐ Back Surgery
- ☐ Breast Biopsy
- ☐ Breast Surgery
- ☐ Bronchoscopy
- ☐ CABG
- ☐ Caesarean Section
- ☐ Cancer Surgery
- ☐ Carotid Endarterectomy
- ☐ Cataract Surgery
- ☐ Cholecystectomy
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Ear Tube
- ☐ Eye Surgery
- ☐ Flexible Sugmoidoscopy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Knee Surgery
- ☐ LEEP
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Prostate Surgery
- ☐ Reconstructive Surgery
- ☐ Phinoplasty
- ☐ Septoplasty
- ☐ Sleeve Gastrectomy
- ☐ Splenectomy
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation

Other: _____

Weight History

Please list the key reasons why weight loss is important to you now:

1:_____

2:_____

3:_____

4:_____

5:_____

Current Weight:_____ Height:_____ Desired Weight:_____

Birth weight:_____ Weight at age 20:_____ Weight 1 year ago:_____

Weight 5 years ago:_____ Weight 10 years ago:_____

Did you have a weight problem?

- Prior to School? □ Yes □ No
- In Grade School? □ Yes □ No
- In Middle School? □ Yes □ No
- In High School? □ Yes □ No

When did you begin to gain excess weight? (Please list age, circumstances, and amount of weight gain): _____
_____
_____

Over the years has your weight gain been gradual, or have you had a "yo-yo" pattern?
_____

List previous weight loss plans, age(s), and results:

Plan	Age(s)	Results

Have you ever been prescribed a weight loss drug? (List names, age, results, and side effects):
_____
_____

Have you ever used over-the-counter weight loss supplements? (List names, age, results, and side effects):_____
_____

Overall, what plan(s) / method(s) have worked best?
_____

Physical / Emotional Issues

List physical symptoms or illnesses you have as a result of your weight:
_____

How does your weight impact you emotionally? (i.e. Depression, poor self-esteem, etc.)
_____

Do you have any history of substance abuse or prescription drug abuse? If so, list what and when:
_____

Have you ever been a victim of:

Physical Abuse □ Yes □ No
Emotional Abuse □ Yes □ No
Sexual Abuse □ Yes □ No

Do you have a history of?

Anorexia □ Yes □ No
Bulimia □ Yes □ No

During the past six months, did you often eat within any two hour period what most people would consider a large amount of food? □ Yes □ No

If so, during those times, did you often feel you couldn't stop eating or control your eating? □ Yes □ No

Do you overeat after dinner to the extent that about half or more of your daily food intake? □ Yes □ No

Do you have trouble falling asleep or staying asleep? □ Yes □ No

If so, do you eat at those times? □ Yes □ No

Do you feel like you do not want to eat in the morning? □ Yes □ No

Are you often mentally preoccupied with food? □ Yes □ No

Hunger / Satiety

Do you feel you have a problem with excess hunger? □ Yes □ No If so, what time(s) of day? ___

During previous diets, was hunger a problem? □ Yes □ No

Do you feel like you do not get "full" or satisfied easily? □ Yes □ No

Do you have problems with portion control? □ Yes □ No If so, at which meal(s)? _____

Do you eat rapidly? □ Yes □ No

Triggers

Please check the types of foods you crave:

□ Sweets
□ Chocolate
□ Starch foods (bread, pasta, potatoes)
□ Fried
□ Crunchy
□ Salty
□ Nuts
□ Popcorn
□Other: _____

Which of these are "trigger foods" (Things you have a hard time controlling portions of)?

_____

Please circle any emotions that lead you to eat and circle severity of overeating:

Stress	Mild	Moderate	Severe
Boredom	Mild	Moderate	Severe
Joy	Mild	Moderate	Severe
Anger	Mild	Moderate	Severe
Loneliness	Mild	Moderate	Severe
Wanting a Reward	Mild	Moderate	Severe
Wanting Comfort	Mild	Moderate	Severe
Other_____	Mild	Moderate	Severe

Please list any activities that lead you to overeat: (i.e. watching TV, work, reading, etc)

_____

Social Environment

Who lives in your home? _____

Are any of them overweight? □ Yes □ No If so, whom:_____

Who plans meals? _____Cooks:_____Shops:_____

Do you use a shopping list? □ Yes □ No

How often do you eat out? _____times per week
"Sit-down" during? _____times per week
Fast food? _____times per week

Do you travel frequently? □ Yes □ No

Do you frequently socialize with food? (entertain guests, invited over by others, etc.) □ Yes □ No

Eating Habits

On a typical day, when do you:
Get up? _____
Start work?_____
Get off work?_____
Go to bed? _____

Meal	**Do you eat? If so, what time?**	**What do you typically eat?**	**Hunger rating from 0-4 (0 = not hungry, 4 = extremely hungry)**
Breakfast			
Mid A.M			
Lunch			
Afternoon			
Dinner			
Evening			

Do you drink Alcohol? □ Yes □ No What type? _____

Average # of Drinks_____/week ____/day

Do you drink coffee? □ Yes □ No □ Caf. Amt per day _____
□ Decaf. Amt per day _____

Do you drink tea? □ Yes □ No □ Caf. Amt per day _____
□ Decaf. Amt per day _____

Do you drink soft drinks? □ Yes □ No □ Diet Amt per day _____
□ Regular Amt per day _____

What other beverages do you drink?
□ Fruit Juice Amt per day _____
□ Milk-Type_____ Amt per day _____
□ Other _____ Amt per day _____

How much water do you drink per day?_____

What foods do you dislike?_____

List any food intolerances or food allergies:_____
_____

Activity / Hobbies

Do you enjoy being physically active? □ Yes □ No

What types of exercise do you currently do?_____

Do you have any plans for exercise? □ Yes □ No

If so, What?_____

List hobbies you have, or activities you enjoy:_____

_____

Support System

What person/people would you look to, to give you support/encouragement in your quest to lose weight?

_____

Who, if anyone, might sabotage your efforts at weight loss? (i.e. food pushers, sources of discouragement) _____

In general, what factors have been the most influential in your weight problem?

_____

What has kept you from being successful at efforts for weight loss?_____

_____

What do you feel you need, or need to do to be successful this time? _____

_____

List any current life stresses:_____

_____

Anything Else:

_____

_____

_____

_____

_____

_____

_____

STOP BANG - Screening for Obstructive Sleep Apnea

Name: _____ Phone: _____ Date: _____

Please answer the following questions to find out if you are at risk for sleep apnea:

S (snore)	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes / No
T (tired)	Do you often feel tired, fatigued, or sleepy during daytime?	Yes / No
O (observed)	Has anyone observed you stop breathing during your sleep?	Yes / No
P (pressure)	Do you have or are you being treated for high blood pressure?	Yes / No

B (BMI)	Is your Body Mass Index greater than 35? (See reverse for calculation)	Yes / No
A (age)	Are you over 50 years old?	Yes / No
N (neck)	Is your neck circumference greater than 16 in?	Yes / No
G (gender)	Are you male?	Yes / No

*If you answered yes to three or more items, you have a high risk of having Obstructive Sleep Apnea.

*If you answered yes to fewer than three items, your risk of having Obstructive Sleep Apnea is considered to be low.

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Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization - NorthStar Medical Specialists may use or disclose the following health care information (check all that apply):

- □ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition: _____
- □ Health care information in my medical record for the date(s): _____
- □ Other (e.g., X-rays, bills)—specify date(s): _____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV/AIDS
- □ Mental Health or Illness
- □ Reproductive Care (minors only)
- □ Sexually Transmitted Diseases
- □ Drug and/or Alcohol Abuse

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

You may disclose this health care information to:

Name (or title) and/or organization of persons: _____

Name (or title) and/or organization of persons: _____

Name (or title) and/or organization of persons: _____

Name (or title) and/or organization of persons: _____

This authorization ends:

- □ on (date): _____
- □ when the following event occurs: _____
- □ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)
- □ This authorization does not have a term date

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.

2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by NorthStar Medical Specialists in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form—a form is available from NorthStar Medical Specialists or
   - Write a letter to NorthStar Medical Specialists

III. **Protection after Disclosure**. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time

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Billing and Financial Policies

Our goal is to provide you with high-quality and efficient care, and maintain a good physician patient relationship. There are many details involved in the process of obtaining payment for the services you receive. In order for us to maintain a smooth process, it is essential that you understand our office policy and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification and contact information. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's information as well. Our billing process works better if you provider social security numbers as well.

Health Insurance Cards: Upon arrival for each appointment, our team will ask to verify your insurance information and will ask to see your insurance card upon check-in. Please bring your card to every appointment, and notify our office of any changes. Intentionally failing to notify us of changes to your insurance coverage may constitute in fraud, and we may be obligated to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Health Insurance Plans: It is your responsibility to understand the provisions and policies of your health insurance plan and coverage. Our office is happy to assist you with questions on your benefits however our team cannot be expected to know the details of your particular plan, as we see several plans in our clinic. We recommend contacting your carrier prior to receiving services in order to verify your coverage level and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, pre-certifications or other required documentation prior to your appointment. If an authorization is not obtained or on file, you will be responsible to pay for services not covered due to no authorization on file.

Copayments: It is our responsibility, as detailed by the terms of our contract with health insurance companies, to collect any co-payment due at the time of your appointment. Please have your payment ready at check in. Co-payments that are not made at the time of service are subject to a processing fee of $10 (with exceptions to Medicare and diagnostic testing).

Balances and/or Deductibles: It is our responsibility to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. Patient balances are billed immediate on receipt of your insurance plan's explanation of benefits. Payments are due immediately after receipt of your bill.

Payment Arrangements: Please contact our office if you are unable to pay your balance in full. If previous payment arrangements have not been made with our office, any account balance outstanding over 60 days will be forwarded to a collection agency. Accounts that are turned over are subject to a $35 processing fee.

Returned Checks: A $25 fee will be charged for any checks returned for insufficient funds. This charge is not covered by your insurance and the fee will be treated the same as our policy for unpaid balances.

Self-Pay Patients: If you do not have health insurance, or we are not contracted with your plan, we offer a discounted cash pay rate. Payment is due at time of service for all office visits; however, for some diagnostic testing and programs, a deposit is required in advance for self-pay patients.

I have read and fully understand the financial policy of NorthStar Medical. I agree to comply with all the above policies and accept responsibility for any payment due as outlined above.

Signature of Patient: _____ Date: _____

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Cancellation Policy

Thank you for choosing NorthStar Medical Specialists to help you achieve a better quality of life. In the interest of conserving your time, we will make every effort to stay on schedule. Your time is valuable and except for emergency treatment of another patient, you can expect us to be prompt.

We understand there are times when it is unavoidable to cancel an appointment, and your call before the appointment during business hours is appreciated.

When you schedule an appointment, that time has been set aside just for you. There will be a charge for appointments cancelled with less than sufficient notice. No-show and late cancellation fees must be paid before future appointments can be scheduled.

NorthStar Medical Specialists utilizes an automatic reminder call system for upcoming appointments. This call is a courtesy to remind patients of their next appointment at our office 48 hours in advance. Please be advised that patients are still responsible for attending their appointment whether or not they hear their reminder call. In addition, failure to use the "confirm" option during the call does not cancel your appointment. All appointments must be cancelled with the front desk personnel during business hours.

We will hold your appointment for 15 minutes after your scheduled start time for any appointments scheduled to last 30 minutes or more. For appointments scheduled for 15 minutes, we can only hold your appointment for 5 minutes after the scheduled start time. If you arrive late on the date of your appointment, you may be asked to reschedule; however, we will do our best to provide an excellent session with the remaining time. High standards of patient care depend upon equal treatment and consideration; therefore sessions must begin and end on time.

The cancellation/no-show fee schedule is as follows:

48-Hour Notice Required for all Appointment Cancellations:

Physician and physician assistant appointments – 30+ minutes	$75
Physician and physician assistant appointments – 15 minutes	$50
Clinician appointments	$45
Respiratory therapy session	$45
Overnight sleep study appointments	$250

Please note, calls to cancel appointments should not be left on the office voice mail within the minimum time frame in attempt to avoid the cancellation fee. Doing so may result in a lapse of the 48-hour notice. If you have any questions or concerns, please do not hesitate to contact our office at (360) 676-1696. Thank you!

I have read and fully understand NorthStar Medical Specialists' Cancellation Policy.

_____ _____

Signature Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. At NorthStar Medical Specialists, we respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others for non-permitted uses and disclosure unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to get authorization to disclose this information for payment purposes.

Use and disclosure of protected health information for treatment, payment, and health operations, to remind you, notification of family, for public health and safety, and other uses as noted below.

For Treatment**:** Information obtained by a therapist, physician, technologist, or other member of our health care team will be recorded in your medical record and used to help decided what care may be right for you.

We may also provide information to others providing your care to help them stay informed about your care.

For Payment**:** We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Health Care Operations**:**

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about your appointments and give you information about treatment alternatives or other health related benefits and services
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
  - Medical review by your health plan;
  - Accounting, legal, risk management, and insurance services;
  - Audit functions, including fraud and abuse detection and compliance programs.

To remind you:
We may remind you by phone, voicemail, or mail, that you have a health care appointment with us, or request that you call us regarding your health care. You have the right to request we contact you at an alternative addressor phone number. If you request this, we will contact you at the alternative location, as requested.

Notification of family and others:
We may disclose your private health information to a “personal representative” (a person who is legally authorized to make health care decision on your behalf, such as a parent of a minor child).
In addition, we may disclose health care information about you to assist in disaster relief efforts.
You have a right to object to this use or disclosure. If you object, we will not disclose it.

For public health and safety purposes as required by law:

- to prevent or reduce a serious, immediate threat to the health of a person or the public
- to public health and legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or death

To report suspected abuse or neglect
To the Food and Drug Administration relating to problems with products
In the course of judicial/administrative proceedings
For law enforcement purposes
To correction institutions if you are in jail
With approved medical researchers

To comply with workers compensation laws
For health and safety oversight activities, e.g., shared health information with the Department of Health
For disaster relief purposes
For work related conditions that could affect employee health
To the military authorities, U.S. and foreign
To funeral directors/coroners consistent with applicable laws
For specialized government functions such as national security purposes

Other uses and Disclosure of protected health information

Uses and disclosures not in this notice as allowed and required by law, or with your written authorization

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this notice;
- Abide by the terms of this notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by visiting us at NorthStar Medical Specialists to pick one up.

Your Health Information Rights

The health and billing records we create and store are the property of NorthStar Medical Specialists. The protected health information in your file, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but if we decide to, we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected Health information, you may make this request in writing.
- Have us review a denial of access to your health information - except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical records, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The privacy rule does not require accounting of disclosure to covered entities for treatment, payment, or health care operations, to the individual (or representative), to persons involved in the individual's health care, or payment for health care, pursuant to an authorization, of a limited data set, for nation security purposes, to law enforcement officials in certain circumstances, incident to otherwise permitted or required uses or disclosures;
- Ask that your health information be given to you by another means, or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance;

For help with these rights during normal business hours, please contact our Privacy Manager at NorthStar Medical Specialists.

To ask for help or complain

If you have questions, want information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Manager at NorthStar Medical Specialists.

If you believe your privacy rights have been violated, you may discuss your concerns with our Privacy Manager. You may also deliver a written complaint to the Privacy Manager at NorthStar Medical Specialists. You may also file a complaint with the US Secretary of Health and Human Services.

We respect your right to file a complaint with us, or the US Secretary of Health and Human Services. If you complain, we will not retaliate against you.

While you participate in your treatment at NorthStar Medical, some of your activities and treatments will be conducted in a group setting. As a result, some of your protected health information may be discussed with you in the group setting. Please sign below if you agree.

_____ _____

Patient Signature Date and Time

_____

Printed Name