ALLIED ANKLE & FOOT CARE CENTERS, P.C.

Patient Registration Form

PATIENT

Patient's Name: Last	First *(legal)*:	Middle Initial:	
SSN#:			
Address:	City:	State:	Zip:
Home Phone #	Work #:	Cell #	
Sex: ☐ Male ☐ Female	Date of Birth:	Age:	
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Employment Status: ☐ Full-Time ☐ Not-Employed ☐ Retired ☐ Part-Time ☐ Self-Employed ☐ Military Duty	Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student	
Employer:	Occupation:		

Emergency Contact Name: _____

Relationship to Patient: ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Phone: _____ ☐ Home ☐ Work ☐ Cell

***Please present your insurance card(s) to the receptionist ***

INSURANCE

Primary Insurance: _____

Subscriber's Name: _____ Subscriber's DOB _____ Subscriber's SSN _____

Subscriber's Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Secondary Insurance _____

Subscriber's Name: _____ Subscriber's DOB _____ Subscriber's SSN _____

Subscriber's Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

FINANCIAL

Guarantor/ Responsible Party **(Required for patients who are under age 18)**

Guarantor Name-Last: First:(legal) Middle Initial:

Address: (if different than patient)

City:	State:	Zip:
Phone #:	Date of Birth:	
	Relationship to patient: ☐ Father ☐ Mother ☐ Guardian	

How did you hear about Allied Ankle & Foot Care Centers?

☐ Yellow Pages Book ☐ Internet
☐ Our Company Website
☐ Former Patient
☐ Doctor: _____
☐ Insurance Company
☐ Family/Friend: _____
☐ Hospital/ER: _____
☐ Sign/ Driving by the Office
☐ Health Fair
☐ Other: _____

Providing your ethnicity/ race is optional, and will not affect the quality of care that you receive at our office. If you choose not to answer race or ethnicity, please check "Unreported/ Refused to Report".

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

Race
☐ White
☐ Asian
☐ Pacific Islander
☐ Black/African American
☐ Native Hawaiian
☐ American Indian or Alaskan Native
☐ More than one race
☐ Unreported/Refused to Report

_____ _____

Patient/Guardian Signature **Date**

MEDICAL HISTORY

This complete record is confidential.

Patient's Name: Last: First: Middle:		Date of Birth: _____ MALE FEMALE
Name of Primary Physician:	Primary Physician Phone number:	May we contact your primary physician for your health records? ☐Yes ☐ No Date Last Seen:
Former podiatrist name:	Former podiatrist phone number:	May we contact your former podiatrist for records?
If any, what kind of podiatric treatment did you have?		When did you have this treatment?
Major foot complaint today is?		
This condition(s) has existed for ___ days ___ weeks ___ months ___ years		Height: ___ft. ___in. Weight: _____ Shoe Size: _____

Check any of the following conditions below that you currently have or have been treated for in the past:

☐ ***NONE***

	Diabetes
	Leg or feet injuries/surgeries
	Bleeding Tendencies
	Leg Cramps
	Heart Problems
	Asthma
	Epilepsy

	Rheumatic Fever
	Kidney Problems
	Liver Problems
	Arthritis
	Bursitis
	High Blood Pressure
	Low Blood Pressure

Any other conditions not listed above, please specify?

Check any Existing Allergies: ☐ No Known Allergies ☐Novocain ☐Penicillin ☐Sulfa Drugs ☐Adhesive Tape ☐Latex ☐Other: *please specify?* _____

Do you take any medicines regularly? Yes or No: *please list* _____

Pharmacy Name: _____ Pharmacy address: _____

	YES	NO	Comment
Do you use alcohol? If yes, how much?			
Do you smoke? If yes, how much?			
Do you use caffeine? If yes, how much?			
Have any family members been treated for diabetes?			
Have you had any injuries or surgeries on your feet or legs?			

ePrescribing software sends prescriptions over the internet to your pharmacy safely and securely. ePrescribing software helps protect your personal information while allowing your provider to access important data such as drug interactions and prescription history.
I agree that Allied Ankle & Foot Care Centers, PC may request and use my prescription medication history from other healthcare providers or pharmacy benefit payers for treatment purposes.
By signing below, I acknowledge that I have read and understand all of the above.

Preferred Notification Method for Preventive Health Reminders: ☐E-Mail ☐Text Message ☐Phone ☐Postal Mail
Email: _____

Primary Language Spoken (Required):_____

I hereby give Allied Ankle & Foot Care Centers, P.C. permission to examine and to provide treatment.

Patient Signature_____ Date_____

ALLIED ANKLE & FOOT CARE CENTERS, P.C.
MEDICINE AND SURGERY OF THE FOOT AND LEG

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name: _____ Date: _____

Cancellation/Rescheduling of an Appointment

Please be courteous and call our office at 770-255-0434 if you need to cancel or reschedule an appointment. Our staff will try their best to schedule your appointment at a more convenient time. We require at least 24 hours notice, so that your appointment time can be reallocated to someone else. ***Cancellations less than 24 hours will be considered as a "no show".***

No Show Policy

A "no show" is someone who misses an appointment without canceling it at least 24 hours in advance or who fails to keep a scheduled appointment. In the event a 24-hour notice is not given, a fee of **$25.00** will be charged for missed office visits.
NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY!

I have read and understand the Cancellation and No Show Policies of the practice and agree to the terms.

_____ _____
Name of Patient **Relationship to Patient (if minor)**

_____ _____
Signature of Patient or Responsible Party **Date**

PO Box 491658, Lawrenceville, Georgia 30049-0028
Tel. 770-255-0434 Fax: 770-255-0434

ALLIED ANKLE & FOOT CARE CENTERS, P.C.

PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

Allied Ankle & Foot Care Centers, PC may offer our patients the opportunity to communicate by electronic communication via E-mail and or text messages. This form provides information about the risks of electronic communication, guidelines for electronic communication, and how we will use electronic communication. It also will be used to document your consent for us to communicate with you by electronic communication via E-mail and/or text messages.

RISKS

Communication by electronic communication, such as E-mail or text messages, has a number of risks which include, but are not limited to, the following:

- Electronic communication can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of electronic communication may exist even after the sender or the recipient has deleted his/her copy.
- Electronic communication can be received by unintended recipients.
- Electronic communication can be intercepted, altered, forwarded, or used without authorization or detection.
- Electronic communication senders can easily type in the wrong electronic communication address.
- Electronic communication can be used to introduce viruses into computer systems.
- Message & data rates may apply, if using text messages as the means of electronic communication.

HOW WE WILL USE ELECTRONIC COMMUNICATION

1. We will limit electronic communication correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2. We will use electronic communication to communicate with you only about non-sensitive and non-urgent issues such as:
    - Questions about prescriptions, use of medical equipment or devices, etc.
    - Routine follow-up questions
    - Appointment scheduling
    - Billing questions
3. All electronic communications to or from you will be made a part of your medical record. You will have the same right of access to such electronic communications as you do to the remainder of your medical file.
4. Your electronic communication messages may be forwarded to another office staff member as necessary for appropriate handling.
5. We will not disclose your electronic communications to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC COMMUNICATION.. CALL 911.

Also, do not use electronic communication for urgent problems. If you have an urgent problem, call our patient services department at 770-255-0434 or go to an urgent care facility.

GUIDELINES FOR ELECTRONIC COMMUNICATION

1. Include the general topic of the message in the "subject" line of your electronic communication. For example, "advice," "prescription," "appointment" or "billing question."
2. The electronic communication message should not be time-sensitive. While we try to respond to electronic communication messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3. Include your name and phone number in the body of the message.
4. Review your message to make sure it is clear and that all relevant information is included before sending.
5. Send us an electronic communication confirming receipt of our message after you have received and read an electronic communication message from us.
6. If your electronic communication requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your electronic communication.
7. Take precautions to protect the confidentiality of electronic communication, such as safeguarding your computer password and using screen savers.
8. Inform us of changes in your email address.

CONSENT TO ELECTRONIC COMMUNICATION:

I may want to communicate with Allied Ankle & Foot Care Centers, PC by electronic communication. I understand the risks of communicating by electronic communication, in particular the privacy risks explained in this form. I understand that Allied Ankle & Foot Care Centers, P.C. cannot guarantee the security and confidentiality of electronic communication. Allied Ankle & Foot Care Centers, PC will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with Allied Ankle & Foot Care Centers, PC by telephone or during a scheduled appointment, and that electronic communication is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or Allied Ankle & Foot Care Centers, PC may stop using electronic communication as a means of communication at any time, upon written notification.

I understand that I may revoke this consent at any time by so advising Allied Ankle & Foot Care Centers, PC in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and by providing my email address and/or cellular phone number, give my consent for electronic communications to and from Allied Ankle & Foot Care Centers, PC via email and/or text message.

Patient Name _____ DOB _____

Date _____ Cell Phone Number _____

Patient (or Guarantor) Signature _____

Email Address _____

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Would you like to give Allied Ankle & Foot Care Centers, P.C. permission to discuss your medical records and/or financial information to another person other than yourself? This can include, but is not limited to your spouse or another family member who might need to ask questions about your account. Please list the name(s) and relationship below.

NAME	RELATIONSHIP TO PATIENT

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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NOTICE OF PRIVACY PRACTICES

Allied Ankle & Foot Care Centers, P.C.

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.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. 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.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. 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: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you 25¢ for each page, $15.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **James Bouchard, DPM**
Telephone: **770-255-0434** Fax: **770-255-0434**
Address: **P.O. Box 491658 Lawrenceville, Ga 30049**