PATIENT HISTORY QUESTIONNAIRE

Today's Date_____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name_____ First Name _____ MI_____
Address_____ Emergency Contact Name_____
City, State, Zip_____ Phone (_____)_____
Work Phone (_____)_____ Date of Last Eye Exam_____
Home Phone (_____)_____ Dilated? ☐ Yes ☐ No
Email Address _____ Referred By_____
Date of Birth_____ Primary Vision Coverage_____
Occupation_____ Secondary Coverage_____
Employer_____

MEDICAL INFORMATION

How is your general health?_____
Do you take medications for any of these systems? (Please check Yes or No boxes.)

Gastrointestinal	☐Yes ☐No	Nervous	☐Yes ☐No	Endocrine	☐Yes ☐No
Ears/Nose Throat	☐Yes ☐No	Urinary	☐Yes ☐No	Blood/Lymph	☐Yes ☐No
Cardiovascular	☐Yes ☐No	Muscles/Bones	☐Yes ☐No	Allergic/Immunologic	☐Yes ☐No
Respiratory	☐Yes ☐No	Integumentary(skin)	☐Yes ☐No	Headaches	☐Yes ☐No
High blood pressure	☐Yes ☐No	Eyes	☐Yes ☐No	Mental	☐Yes ☐No

Please explain_____
Diabetes ☐ Yes ☐ No_____Type_____Date of diagnosis_____
Allergies to medication ☐ Yes ☐ No Which?_____Reactions?_____
Other health problems_____
Current medications_____
Have you had any operations? ☐ Yes ☐ No Kind?_____When?_____
Name of family doctor and/or primary care physician_____
Date of last visit?_____Date your blood pressure was last checked?_____

FAMILY HISTORY

High blood pressure	☐Yes ☐No	Relation_____	Macular degeneration	☐Yes ☐No	Relation_____
Diabetes	☐Yes ☐No	Relation_____	Retinal detachment	☐Yes ☐No	Relation_____
Glaucoma	☐Yes ☐No	Relation_____	Cataracts	☐Yes ☐No	Relation_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems ☐ Yes ☐ No What Kind?_____
Have you had any eye operations? ☐ Yes ☐ No Type?_____Date_____
Have you had any eye injury? ☐ Yes ☐ No Kind?_____Date_____

Do you have glaucoma?	☐Yes ☐No	Cataracts?	☐Yes ☐No	Dry eyes?	☐Yes ☐No
Macular degeneration	☐Yes ☐No	Retinal detachment?	☐Yes ☐No	Blurred vision?	☐Yes ☐No
Do you wear glasses?	☐Yes ☐No	Contact Lenses?	☐Yes ☐No	Type_____	

Additional Information: _____

DOCTOR USE ONLY

Reviewed by_____ ☐ No changes Date_____
Reviewed by_____ ☐ No changes Date_____
Reviewed by_____ ☐ No changes Date_____

Carmi Eye Care

Dr. Lars Gentry O.D.

1207 W. Main St. • Carmi, IL 62821

(618) 384-3411

"Welcome to our family of patients! Take a moment and tell us all about you. Sit back, relax, and let us take it from here. Our team is ready to provide customized vision care for you and your family."

Please provide MEDICAL and VISION insurance card(s) upon registration.
Please provide a copy of your current vitamin/medication list upon registration.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F SS#: _____ - _____ - _____

Cell Phone: _____ - _____ - _____ Home Phone: _____ - _____ - _____ Email: _____

Address _____ City: _____ State: _____ Zip: _____

Grade in School: _____ Occupation: _____ Employer: _____

Emergency Contact: _____
(name) *(relationship)* *(cell phone number)*

Do you prefer to recieve calls at: Home Work Cell No Preference

Married Widowed Single Minor Separated Divorced Partnered for_____years

Spouse or partner's name_____ Employer_____ Work Phone(_____)_____ SS#_____

Whom may we thank for referring you to us?_____

Tell us the most important wish to change about your vision performance _____

What are you interested in? ☐ **LASIK** ☐ **Implantable Contact Lenses** ☐ **Cataract Surgery** ☐ **other** _____

What should your fashion eyewear say about you? "I am ....." ☐ **Athletic** ☐ **Casual** ☐ **Professional** ☐ **Trendy**

Problem with current glasses? _____ ☐ **No problems! I love my current glasses**

How many digital devices do you use? _____ **Have you ever tried digital computer glasses?** ☐ **Yes** ☐ **Tell me more**

Preferred contact lenses replacement schedule? ☐ **Daily** ☐ **Monthly** ☐ **Extended Wear** ☐ **No thanks, maybe later**

Do you protect your eyes with polarized sunwear? ☐ **Yes** ☐ **No** **Hobbies?** _____

How did you hear about our quality of care? _____

The following individual(s) are allowed access to my health care records and private health information:

First Name:_____ Last Name:_____ Relationship:_____ Cell Phone:____-____-_____

Address:_____ City:_____ State:_____ Zip Code:_____

First Name:_____ Last Name:_____ Relationship:_____ Cell Phone:____-____-_____

Address:_____ City:_____ State:_____ Zip Code:_____

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Financial Policy

"Thank you for taking the time to read our financial policy. If you have additional questions our Insurance & Billing Specialists are always available for consultation. We are happy to help guide you through the maze of insurances."

PAYMENT

For all medical services and eye exams, the co-payment and/or deductible is due on the date of service. For glasses, contact lenses, and accessories provided by the Carmi Eyecare Center, ½ payment must be paid at the time of the order is placed. The balance is due on delivery. We accept cash, personal checks, credit cards,and personal finance.

INSURANCE

At each visit to the Carmi Eyecare Center, we will need a copy of all of your current insurance card(s) if you have had any changes to your insurance. **As a courtesy**, we will bill your insurance company for the covered services provided to you. Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of the benefit information given to us by insurance companies. If for some reason your insurance company fails to pay, you will be expected to pay the balance in full within 60 days. If you have not met the deductible amount for the year, and the insurance company applies your covered charges to your annual deductible you will be billed for the amount of the service(s). **You will be billed for all charges that are denied by your insurer due to no authorization or for us being out of network.** If insurance information, including copies of your cards, is not provided on the day of service, you may be responsible for filing the claim yourself.

NON-COVERED SERVICES

Insurance regulations suggest that we inform you in advance if a service may not be covered or fully reimbursed by your insurance carrier. A non-exhaustive listing of possible non-covered services includes: refractions, topography, eye photography, eye imaging, visual field testing, lab cultures, eye pharmaceuticals, eyewear, contact lenses and solutions, eye supplements, etc.

MEDICARE

For patients who have Medicare, you must have **Part B** coverage for Medicare to pay your claim. You will be responsible for any charges Medicare or your supplemental insurance does not cover. This may include, but is not limited too: deductibles, refractions, eyewear, and other testing our physicians may order.

NON-INSURANCE

For patients without insurance, payment is due at the time service is rendered.

PRODUCT

A 50% deposit is due at the time materials are ordered. The remaining balance is due at the dispensing of materials. This office is not responsible for any material(s) left after 90 days. Deposits are non-refundable.

LATE FEE

A late fee of $25.00 will be added to your balance when the account is 60 days past due.

I (print patient name) _____ have read, understand, and agree to the conditions above. I have been informed in advance of the potential for non-covered services to protect my eyesight. I have advised the doctors to proceed with such services, whether or not they are covered by my insurance. I agree to be personally and fully responsible for payment. I acknowledge that I reviewed a copy of the Carmi Eyecare Center's Notices of Privacy Practices. By signing below, I authorize the release of any medical or other information necessary to process my insurance claims and transfer records.

X_____ *Today's Date:* ____ /____ /_____

Patient Signature (or Guardian if patient is a minor)

Patient's Health History

Today's Date _____ / _____ / _____

Patient First Name: _____ Last Name: _____ Middle Initial: ____ Date of Birth: ___/___/____

General Care Provider _____ MD / DO / Other _____ Location _____

Allergies to Medications _____ Preferred Pharmacy _____

Your Eye Symptoms

Burning Eyes	N	Y	RT/LT/BOTH	Flash(es)	N	Y	RT/LT/BOTH	Itchy Eyes	N	Y	RT/LT/BOTH
Discharge, Color	N	Y	RT/LT/BOTH	Floater(s)	N	Y	RT/LT/BOTH	Light Sensitive	N	Y	RT/LT/BOTH
Double Vision	N	Y	RT/LT/BOTH	Glare	N	Y	RT/LT/BOTH	Redness	N	Y	RT/LT/BOTH
Eye Infection	N	Y	RT/LT/BOTH	Gritty Eyes	N	Y	RT/LT/BOTH	Tired Eyes	N	Y	RT/LT/BOTH
Eye Pain/Sore	N	Y	RT/LT/BOTH	Halos/Distortion	N	Y	RT/LT/BOTH	Watery Eyes	N	Y	RT/LT/BOTH

Your Eye History

Specialist _____ **Next Follow up** _____

Blindness	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Cataract	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Color Blindness	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Crossed Eyes	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Diabetic Eye Disease	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Foreign Object Removal	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Glaucoma	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Macular Degeneration	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Retinal Detachment	N	Y	RT/LT/BOTH	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Other _____			RT/LT/BOTH	Medications/Surgery _____	

Your Allergy History

Specialist _____ **Next Follow up** _____

Environmental Allergies	N	Y	Specify _____	Medications/Surgery _____
Collagen/Silicone	N	Y	Specify _____	Medications/Surgery _____
Metal/Nickel	N	Y	Specify _____	Medications/Surgery _____
Other _____			Specify _____	Medications/Surgery _____

Your History of Cancer

Type _____	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Other _____			Medications/Surgery _____	

Your Cardiovascular History

Specialist _____ **Next Follow up** _____

Blood Clot / Thrombosis	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Elevated Cholesterol	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
High or Low Blood Pressure	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Murmur / Palpitations	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent
Other _____			Medications/Surgery _____	

Constitutional

Specialist _____ **Next Follow up** _____

Fever	N	Y	Medications/Surgery _____	
Weight Loss or Gain	N	Y	Medications/Surgery _____	Exercise? Diet? Portion Control? _____
Other _____			Medications/Surgery _____	

Your Endocrine History ***Specialist*** _____ ***Next Follow up*** _____

Crohn's Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Diabetes N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Type? _____ How long? _____ A_1C _____ Avg. FBS _____ Check How Often? _____

High or Low Blood Sugar N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

High or Low Thyroid N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Gastrointestinal History ***Specialist*** _____ ***Next Follow up*** _____

Acid Reflux N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Diverticulosis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Gall Bladder N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Ulcer N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Genitourinary History ***Specialist*** _____ ***Next Follow up*** _____

Are you Pregnant? N Y # of Weeks _____ Complications? _____ Medications _____

Birth Control N Y Medications/Surgery _____

Bladder / Kidney N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Prostate N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Transmitted Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Ear/Nose/Throat History ***Specialist*** _____ ***Next Follow up*** _____

Dry Throat / Mouth N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Seasonal Allergies N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Sinus Congestion N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Blood/Lymph History ***Specialist*** _____ ***Next Follow up*** _____

Anemia N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Bleeding Problems N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Hepatitis Type _____ N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Transfusion / Dialysis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Immune History ***Specialist*** _____ ***Next Follow up*** _____

Autoimmune Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Lupus N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Sjogren's N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Skin History ***Specialist*** _____ ***Next Follow up*** _____

Psoriasis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Rosacea N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Melanoma(s) N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Suspicious Lesion(s) N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent

Other _____ Medications/Surgery _____

Your Bone/Joint/Muscle History ***Specialist*** _____ ***Next Follow up*** _____

Muscle Pain N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Neck Pain N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Juvenile Arthritis N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Osteo Arthritis N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Rheumatoid Arthritis N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Other _____ *Medications/Surgery* _____

Your Neurological History ***Specialist*** _____ ***Next Follow up*** _____

Headache N Y *Location* _____ *How Often?* _____ *Wake you up at night?* _____

How does vision change? _____ *Medications/Surgery/MRI/CT* _____

Migraine N Y *Location* _____ *How Often?* _____ *Wake you up at night?* _____

How does vision change? _____ *Medications/Surgery/MRI/CT* _____

Seizure(s) N Y *At what age?* _____ *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

How does vision change? _____ *Medications/Surgery/MRI/CT* _____

Stroke N Y *At what age?* _____ *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

How has vision changed? _____ *Medications/Surgery/MRI/CT* _____

Other _____ *Medications/Surgery* _____

Your Psychiatric History ***Specialist*** _____ ***Next Follow up*** _____

ADD/ADHD N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Alzheimer's Disease N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Anxiety N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Dementia N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Depression N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Spectrum Condition N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Other _____ *Medications/Surgery* _____

Your Respiratory History ***Specialist*** _____ ***Next Follow up*** _____

Apnea, Sleep N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Asthma N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Chronic Bronchitis N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

COPD N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Emphysema N Y *Medications/Surgery* _____ *Family? Mother/Father/Sibling/Grandparent*

Other _____ *Medications/Surgery* _____

Social History How often do you use? Cigarettes _____ Tobacco _____ E-Vape _____

What other substances do you use? _____ How often do you consume alcohol? Never ☐ Socially ☐ Often ☐

Thank you for sharing your confidential health information. Please return this completed section to the reception team.

Acknowledgment Of Receipt

I acknowledge that I recieved a copy of _____ O.D.,

Notice of Privacy Practices. Date _____

Patient Name _____ Signature _____

Notice of Privacy Practices

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect August 1, 2014 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 such changes are permitted applicable by law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our 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 the Notice.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations, For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing your treatment.

Payment: We May use and disclose health information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services received. For example, we may give your health plan information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations, Healthcare operations include quality assessment and improvement actives, reviewing the competence of qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing actives.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose in to anyone for any purpose. If you give us authorization, you may revoke it in writing anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family & Friends: We must disclose your health information you, as described in the Patient Rights section of the Notice. We may disclose you health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved with Care: We may use or disclose health information to to notify, or assist in the notification of (including identifying or locations) a family member, your person representative or another person responsible for your care, of your location your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the persons involvement your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Appointment Reminders: We may use or Disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, text messages , or letters).

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Special Circumstances

Required by Law: We may use or disclose your health information when we are required to do so by law.

Business Associates: 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.

National Security: We may disclose to military authorize the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security actives. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Data Breach Notification Purpose: We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved with a lawsuit or a dispute, we may disclose health information in response to a court or administrative order. We also may disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting law enforcement official.

Inmates or Individual in Custody: If you are an inmate of the correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official.

Patient's Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You much make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will follow Oklahoma Statute Title 76 Section 19 in reference to changes).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 3 years, but not before January 1 2011, If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclose of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement(except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your Request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Out-of-Pocket Payments: If you paid of-of-pocket in full for a specific item or services, you have the right too ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operation, and will honor that request.

Right To request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain Location. For example, you can ask that we only contact you by mail or at work. to request confidential communications, you must make your request in writing. your request must be Specify how or where you wish to be contacted. We will accommodate reasonable requests.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclose of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may address to file your 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. We support your right the privacy of your 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.