Rehabilitation Specialists of Monroe

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Dear Patient:

Welcome to Rehabilitation Specialists of Monroe! We hope you will find your experience here a satisfying one.

Enclosed you will find a New Patient Insurance Form and a New Patient History Form. Please fill out the forms completely and bring them with you to your first appointment. If you are a Worker's Comp or Auto Accident patient, just put your claim number and billing information in the space provided for insurance information. When filling out the history forms, bear in mind that we are asking about your complete history. If you have any questions about filling out the forms, please don't hesitate to call us.

We accept most insurance. If you have an insurance that requires a referral, it is your responsibility to obtain the referral and to keep track of how many visits are on it. Please make sure you bring your referral with you. Remember to bring all of your insurance cards. If you have a co-pay, please be prepared to pay it at the time of service.

If you are a self-paying patient, please bring payment with you. We accept cash, checks, American Express, Discover, Master Card and Visa.

Please bring any recent test results (X-ray, CT scan, MRI, lab work etc.) pertaining to your current complaint/condition with you. These tests may be of assistance to the doctor, and can also minimize the chance of repeating tests that your insurance may not pay for.

We also ask that you do not use cologne or perfume, as many people are allergic to them.

Again, if you have any questions, please don't hesitate to call our office.

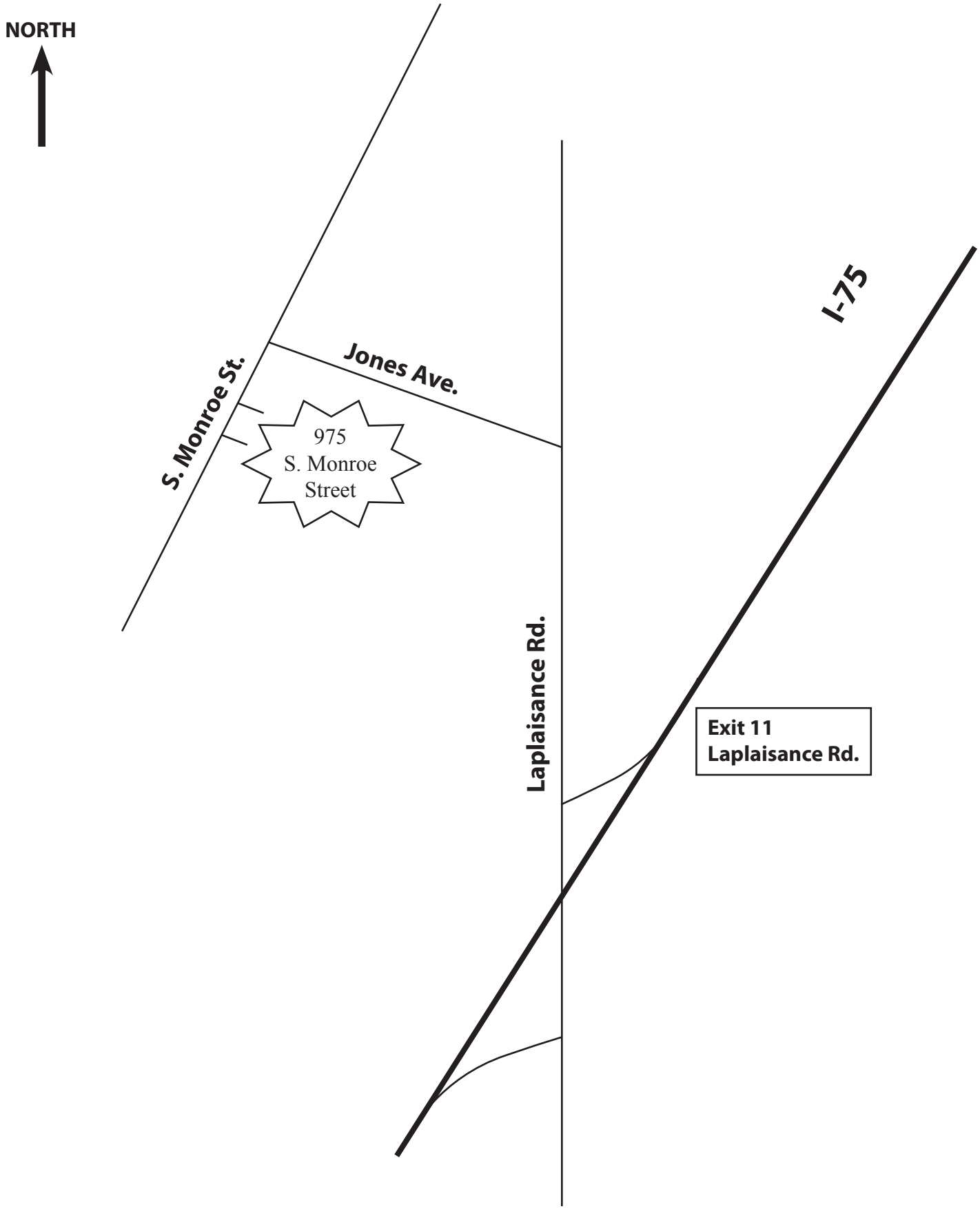
Sincerely,

Receptionist
Rehabilitation Specialists

975 S. Monroe Street, Suite C, Monroe, Michigan 48161
Tel: (734) 241-0560 Fax: (734) 241-3230
www.mindbodyandmotion.com

Rehabilitation Specialists

975 S. Monroe St., Suite C, Monroe, MI 48161
Call: (734) 241-0560



Patient Information

Patient Name: _____ Date: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency contact: _____ Phone: _____

Emergency contact relationship: _____

Date of Birth: _____ Social Security #: _____

Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Name of Spouse: _____

Who referred you to us? _____

Who is your primary care physician? _____

Is this injury due to: ☐ Auto Accident ☐ Employment Injury Date of Injury: _____

Do you have an attorney for the above injury? _____ Phone #: _____

Name & Address: _____

_____

Insurance Information

Primary: Subscriber Name: _____

SS #: _____ Date of Birth: _____

Relationship to patient: _____ Policy Number: _____

Employer: _____

Insurance Name & Address: _____

_____

Secondary: Subscriber Name: _____

SS #: _____ Date of Birth: _____

Relationship to patient: _____ Policy Number: _____

Employer: _____

Insurance Name & Address: _____

_____

YOU WILL BE CHARGED A FEE FOR ALL MISSED APPOINTMENTS WITH THE DOCTOR OR THERAPIST.

Assignment of Benefits/Authorization for Treatment:

●*I hereby authorize treatment and release of information to my insurance carrier and/or physician. I further authorize that payment of benefits be made to the provider on my behalf, (to include medigap carriers).* ●

●*I understand that my insurance may not cover Osteopathic Manipulative Therapy and treatment and that I may be responsible for these and all other charges not covered by my insurance.*●

Records Release Authority

To Whom It May Concern:

I hereby request that you release to:

Rehabilitation Specialists of Monroe
975 S. Monroe St., Suite C
Monroe, MI. 48161

a complete copy of my records/test results including but not limited to:

Medical Tests Previously Performed

	Date Performed	Where Performed	City & State
Cat Scan	_____	_____	_____
M.R.I.	_____	_____	_____
Ultrasound	_____	_____	_____
E.M.G.	_____	_____	_____
X-Rays	_____	_____	_____
Bone Scan	_____	_____	_____
Lab Work	_____	_____	_____
Other	_____		

I acknowledge that I have read and understand the above assignment of benefits, authorization for treatment, and records release statements.

Patient Name:_____/_____
PRINT SIGNATURE

Social Security Number:_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

Witnessed by:_____ Date of Request:_____

Financial Policy

We at Rehabilitation Specialists, take pride in offering service of a value that exceeds the charge. We expect that you, too, will value our service and our relationship.

1. We do cooperate with all insurances, and participate with most. However, the final responsibility lies with you, the patient. We will do our best to pre-authorize your treatment here, but that does not guarantee payment from your insurance company.
2. If your insurance requires a referral, it is your responsibility to bring one with you, or you will be billed for the service rendered.
3. Payment at time of service is required for all co-pays and non-covered services.
4. If you are a self-paying patient, payment in full at time of service receives a substantial discount of 30%--but you must pay at time of service.
5. We will notify you if your insurance company rejects or fails to respond to our billing. At that time you will become responsible for paying the balance in full.
6. Payment in full within 10 days of rejection notice will be considered same as cash at time of service and eligible for the discount.
7. To be eligible for the discount, please make arrangements with our staff as soon as you are notified of a transfer to your responsibility.
8. Notify us immediately if there is a hardship that would not allow you to pay for the services received here. Our billing staff will work with you to help you meet your responsibility here while enabling you to take care of your other obligations.
9. Please notify us as soon as possible of any changes in your insurance coverage. Failure to do so will result in you being charged until such time as the new information is received.
10. Any new injuries may require a new claim.
11. Any cancellations received less than 24 hours prior to your appointment time will be subject to a no-show fee: fifty ($50.00) dollars for initial appointments and pain block appointments and twenty-five ($25.00) dollars for all other appointments. This fee is your responsibility. It will not be billed to your insurance.

I have read and understand the above written financial policy.

Signed: _____ Witnessed: _____ Date: _____

Rehabilitation Specialists

New Patient History Intake Form

Today's Date:_____/_____/_____

Patient Name: _____ D.O.B._____/_____/_____ Sex: M F

Home Phone:_____ Work Phone:_____

Referred By:_____ Phone #/Address:_____

Family Physician:_____ Last Seen On_____/_____/_____

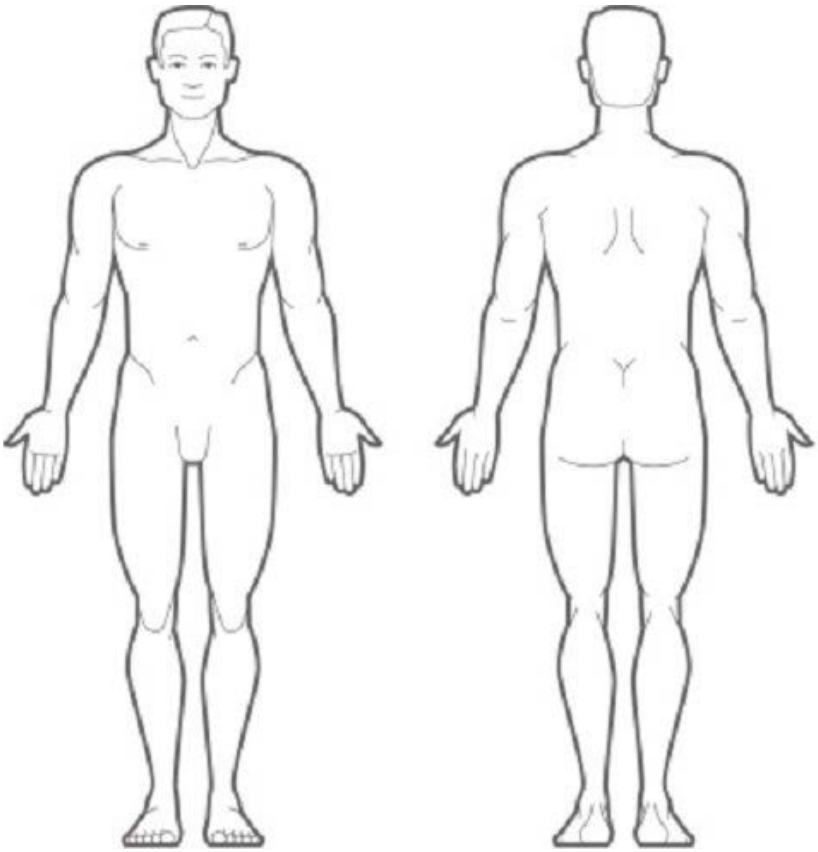
Chief Complaint:

1. What is your primary physical complaint?

_____

_____

2. Where do you feel the above? (Please use vertical lines [| | |] to indicate pain and horizontal lines [==]to indicate numbness or tingling on body chart front and back.)



3. Do you have any weakness? Where?_____ or swelling? Where?_____

History of Present Illness:

4. What was the date of onset? (Date of injury if applicable.)_____

5. Describe how or why the above problem started: _____

_____

_____

_____

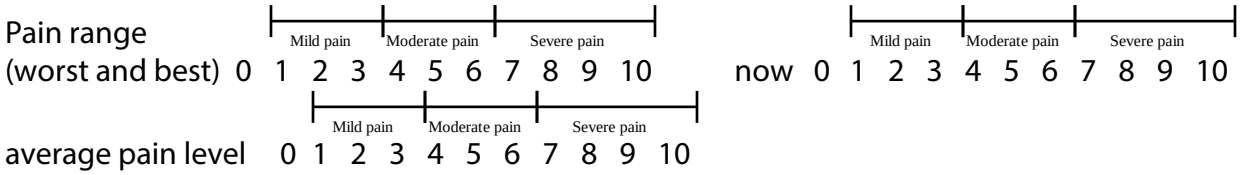
_____

6. Describe the quality of your pain [circle the appropriate word(s).]

intermittent	dull	radiating/shooting	aching	grinding/bone on bone
constant	numb	generalized	stabbing	
throbbing	burning	sharp	toothache	pressure/heaviness
tingling	localized	nauseating	pins & needles	

other: _____

7. On a pain scale of 0 (none) to 10 (requiring Emergency Room visit), circle the number that best describes the severity of the condition.



8. Average Activity level 0 (no activity) to 10 (doing everything that is needed or wanted)

0 1 2 3 4 5 6 7 8 9 10

9. Are you better or worse with any of the below?
For all of the below, indicate how long you can tolerate doing it.

	Better	Worse	How long?		Better	Worse	How long?
sitting				twisting			
standing				heat			
walking				ice			
lying down				rest			
bending				other _____			
lifting			(How much in pounds?)				

10. What kind of treatment have you had for this condition and when? (Including physical therapy, chiropractic, pain blocks, etc.) Did it help?

_____

_____

_____

11. Current Activities:_____

Activities prior to this problem:_____

12. **Studies:** What studies have you had for this condition? (Circle all that apply and give date.)

C.T. _____ MYELOGRAM _____ BLOOD WORK _____

EMG _____ X-RAYS _____ BONE SCAN _____

MRI _____ ARTHROGRAM_____ ULTRASOUND _____

Review of Systems: Please put check mark in boxes next to all that apply.

General:

☐ Weight loss ☐ Appetite changes ☐ Change in daily activities ☐ Sleep difficulties

Head:

☐ Headaches ☐ Loss of consciousness ☐ Seizures

Eyes:

☐ Blurry vision ☐ Double vision ☐ Spots before your eyes

Ears:

☐ Hearing impairment ☐ Bleeding from the ears
☐ Other discharge from the ears ☐ Buzzing or other strange noises from the ears

Nose:

☐ Sinus problems ☐ Nasal injury or surgery ☐ Bleeding from the nose

Mouth/Throat:

☐ Sores in the mouth ☐ Tonsil problems ☐ Difficulty swallowing
☐ Dental problems ☐ Drainage in the back of the throat ☐ Difficulty chewing

Heart:

☐ Irregular heartbeat ☐ Chest pain ☐ Circulation problems ☐ Dizziness or lightheadedness

Lungs:

☐ Shortness of breath ☐ Difficulty breathing when lying flat to sleep ☐ Cough
☐ Cough productive of blood or thick or excessive amounts of sputum

Abdomen:

- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Frequent use of antacids
- ☐ Gastric reflux
- ☐ Indigestion
- ☐ Change of bowel habits
- ☐ Poor control of bowel

Urinary:

- ☐ Change in urine habits
- ☐ Frequency of urination
- ☐ Burning with urination
- ☐ Blood in the urine
- ☐ Night time urination
- ☐ Decreased strength of urine flow
- ☐ Involuntary loss of urine

Reproductive:

- ☐ Current vaginal or penile discharge or irritation
- ☐ Change in sexual functioning

Menstrual history:

- ☐ Irregular periods
- ☐ Excessive bleeding
- ☐ Cramps
- ☐ Headaches
- ☐ Swelling
- ☐ Mood swings
- ☐ Postmenopausal
- ☐ Spotting

Extremities (arms and/or legs):

- ☐ Aches
- ☐ Pains
- ☐ Stiffness
- ☐ Redness
- ☐ Color change
- ☐ Numbness or tingling
- ☐ Loss of sensation
- ☐ Leg cramps
- ☐ Leg jerking
- ☐ Ankle swelling
- ☐ Loss of balance
- ☐ Unstable walking pattern

Mental:

- ☐ Decrease in memory
- ☐ Decreased concentration
- ☐ Depressed mood
- ☐ Mood swings
- ☐ Decreased attention span
- ☐ Frequent emotional outbursts
- ☐ Tendency to "hold" emotions in

Past Medical History: Please put check mark in boxes next to all that apply.

Heart:

- ☐ Angina
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Arrythmia
- ☐ Mitral Valve Prolapse
- ☐ Other _____
- ☐ Hypotension
- ☐ Congestive Heart Failure

Lungs:

- ☐ Emphysema
- ☐ Asthma
- ☐ COPD
- ☐ Other _____
- ☐ Cancer
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis
- ☐ Pulmonary Hypertension
- ☐ Bronchitis
- ☐ Pneumonia

Abdomen:

- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ I.B.S.
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Gastritis
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Pancreatitis
- ☐ Crohn's Disease
- ☐ Stomach Cancer
- ☐ Colon Cancer
- ☐ Malabsorption Syndrome
- ☐ Umbilical Hernia(s)
- ☐ Inguinal Hernia(s)
- ☐ Appendicitis
- ☐ Other _____

Vascular:

□ Poor Circulation Disorder(s) □ Foot or Leg Ulcer □ Blood Clot to Legs
□ Raynaud's Disease/Phenomena □ Phlebitis

Endocrine:

□ Diabetes □ Hyperthyroidism □ Hypothyroidism
□ Adrenal Disorder □ Other_____

Rheumatic:

□ Rheumatoid Arthritis □ Osteoarthritis □ Lupus
□ Fibromyalgia □ Gout □ Chronic Fatigue Syndrome
□ Other_____

Neurological:

□ Seizures □ Multiple Sclerosis □ Neuropathy
□ Head Injury □ Alzheimer's Disease □ Plexopathy
□ Migraine Headaches □ Brain Aneurysm □ Radiculopathy
□ Tension Headaches □ Brain Cancer □ Carpal Tunnel Syndrome
□ Cluster Headaches □ Parkinson's Disease □ Shingles
□ Stroke(s) □ Other _____

Throat:

□ Esophagitis □ Throat Cancer □ Dysphagia
□ Hiatal Hernia □ Other_____

Breasts:

□ Breast Cancer □ Fibrocystic Disease □ Other_____

Reproductive and Urinary:

□ Uterine Cancer □ Penile Cancer □ Urinary Tract Infection
□ Uterine Fibroids and/or Polyps □ Testicular Cancer □ Pyelonephritis
□ Endometriosis □ Yeast Infections □ Bladder Cancer
□ Pelvic Inflammatory Disease □ Prostate Cancer □ Kidney Cancer
□ Sexually Transmitted Diseases □ Prostatitis □ Kidney Stone(s)
□ Cervical Cancer □ Benign Prostatic Hypertrophy (BPH) □ Other _____
□ Vaginal Cancer

Mental:

□ Depression □ Manic/Depressive (Bipolar) Disorder □ Schizophrenia

Other Diseases Not Listed Above:_____

Current Medications (including medical marijuana and natural products): _____

_____

[Previously Tried Medications: _____

_____**]**

Allergies: _____

Past Surgical History (give dates also): _____

Previous Accidents or Traumas (including birth trauma) (give dates also): _____

_____

Family History: Do any medical problems run in the family, and if so, what are they and who?

_____

_____

SOCIAL HISTORY: Single Married Divorced Widowed R or L handed

What is your current work situation? (please circle) Full Restricted Student Retired
Disability: Temporary Permanent Full Partial

Occupation:_____ Employer:_____

Is your present complaint due to a work-related injury? _____ Last Day Worked: ____/____/____

Do you have an attorney regarding this? _____ Are you in litigation for this? _____

Children? Male (ages):_____; Female (ages):_____ Health:_____

What is your religious/spiritual orientation?_____

When do you drink alcohol and how much?_____

How much tobacco do you use (smoke, chew, etc.)?_____ and for how long? _____

Family History (parents and siblings):	Male	Female	Personal history:	Male	Female
Alcohol abuse	☐	☐		☐	☐
Illegal drug use	☐	☐		☐	☐
Prescription drug abuse	☐	☐		☐	☐

Individual Mental Health:			Other		
Diagnosis of ADD, OCD,			Age 16-45 years	☐	☐
bipolar, schizophrenia	☐	☐	History of pre-adolescent		
Diagnosis of depression	☐	☐	sexual abuse	☐	☐

_____L M H

Goals & Expectations: Describe what you would like us to be able to do for you specifically.

_____

_____

Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

NOTICE OF PRIVACY PRACTICES
For
Rehabilitation Specialists of Monroe

(referred to in this document as "the practice")

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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

A. 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 treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. W e may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the Hospitalization.

We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. W e may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of the practice and to provide quality care to all patients. Health care operations include such activities as:

- Quality assessment and improvement activities.
- Employee review activities.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews legal services and maintaining compliance programs.
- Business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment.
- To inform you of health-related benefits or services that may be of interest to you.
- To contact you to raise funds for the practice or an institutional foundation related to the practice. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons, including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any Federal, State or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. W e will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

As required by law for reporting of certain types of wounds or other physical injuries.
Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
Under certain limited circumstances, when you are the victim of a crime.
To a law enforcement official if the practice has a suspicion that your death was the result of criminal conduct.
In an emergency in order to report a crime.

G. To Coroners. Funeral Directors. and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of A Serious Threat To Health Or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, the Federal regulations authorize the practice to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation. The practice may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. W e can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. **The right to inspect and copy your protected health information.** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The practice is not required to agree to a restriction that you may request. W e will notify you if we deny your request to a restriction. If the practice does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to have your physician amend your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by the practice. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to

friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. we are not required to provide an accounting for disclosures that take place prior to April l4, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any l2-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The practice is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the practice changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the practice and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the practice by contacting the practice's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The practice's contact person for all issues regarding patient privacy and you rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the practice, can be mailed to the Privacy Officer by sending it to:
Rehabilitation Specialists of Monroe, P.C.
876 Stewart Road Suite D.
Monroe, Michigan 48162
ATTN: Privacy Officer
The Privacy Officer can be contacted by telephone at (734) 241-0560

IX. Effective Date

This Notice is effective April 14, 2003.