Rehabilitation Specialists of Monroe

Keith R. Barbour, D.O., F.A.A.P.M.&R., F.A.O.C.R.M.
Timothy J. Kellie, C.N.P.
Jillian C. Scott, F.N.P.-C.

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

905 N. Macomb Street, Suite 3, Monroe, Michigan 48162
Tel: (734) 241-0560 Fax: (734) 241-3230
www.mindbodyandmotion.com

REHABILITATION SPECIALISTS OF MONROE

Patient Information

Date:

Patient Name:		**Preferred Name:**	
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**	
Emergency Contact:	**Phone:**	**Relationship:**	
Date of Birth:	**Social Security#**		
Email Address:			
Marital Status: Single	Married	Widowed	Divorced Partner
Name of Spouse/Partner:			

Race:	Ethnicity:	Sex assigned at birth:	Gender Identity(optional):	Sexual Orientation (optional):
____White	____Hispanic/Latino	____Male	____Male	____Straight/Heterosexual
____American Indian	____Not Hispanic/Latino	____Female	____Female	____Lesbian, Gay, Homosexual
____Asian	____Decline	____Undifferentiated	____Transgender Male	____Bisexual
____Black/African American			____Transgender female	____Other: _____
____Hispanic/Latino	Language:	Preferred Pronoun: (Optional)	____Genderqueer, not M/F	____Decline
____Native Hawaiian/Pacific Islander	____English	____He	____Other	
____Other:_____	____Other:_____	____She	____Decline	
____Decline		____They		

Who referred you to us? **Who is your primary care physician?**

Is this injury due to: _____auto accident _____employment **Date of injury:**

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

Insurance Information

PRIMARY

Subscriber Name: **SS#** **DOB**

Relationship to Patient: **Policy Number:** **Group #:**

Employer: **Insurance Name:**

SECONDARY

Subscriber Name: **SS#** **DOB**

Relationship to Patient: **Policy Number:** **Group #:**

Employer: **Insurance Name:**

REHABILITATION SPECIALISTS

New Patient History Intake Form

Patient name: _____ Preferred Name: _____ Date of Birth: _____

Chief Complaint Where is your primary physical complaint?

Do you have any numbness or tingling? If so where?

Do you have any weakness? If so where?

Do you have any swelling? If so where?

Is your pain better/worse at a specific time of day or after an activity?

Quality of Pain (please circle)

Intermittent	Tingling	Burning	Generalized	Aching	Pins/needles	Other:
Constant	Dull	Localized	Sharp	Stabbing	Grinding/bone on bone	
Throbbing	Numb	Radiating/shooting	Nauseating	Toothache	Pressure/heaviness	

History of Present Illness: Date of onset (date of injury if applicable) :

Describe how or why the above problem started:

Average pain level on a pain scale of 0 (none) to 10 (requiring Emergency Room visit), what number best describes your pain	0 1 2 3 4 5 6 7 8 9 10
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

What kind of treatment have you had for this condition and when? (Including physical therapy, chiropractic, pain blocks, etc.) Include names of clinics, doctors.

Did it help?

Is your pain getting worse over time? If yes, please describe:

Goals for treatment here:

Current Medications (including medical marijuana and natural products):

Previously Tried Medications:	
Surgical History:	Previous accident or Traumas (including birth trauma) (give dates also):
Allergies:	Family History: Do any medical problems run in the family, and if so, what are they and who?

Review of Systems (please put check mark in boxes next to all that apply to **Current Symptoms**):

	Constitutional		**Eyes**		**Musculoskeletal**		**Reproductive**
	Appetite changes		Blurry vision		Aches		Male
	Sleep difficulties		Double vision		Loss of balance		Change in sexual function
	Weight loss		Spots before eye		Pain		Discharge
	Change in daily activities		Other		Stiffness		Female
	Other				Leg cramps		Cramps
			Cardiovascular		Unstable walking pattern		Discharge
	Head		Chest pain		Leg jerking		Headaches
	Dizziness		Swelling of legs		Other		Mood swings
	Headaches		Circulation problems				Excessive bleeding
	Seizures		Extremity discolored		**Psychiatric**		Swelling
	Loss of consciousness		Irregular heartbeat		Depression		Change in sexual function
	Other		Dizziness/lightheaded		Memory loss		Postmenopausal
			Other		Decreased attention span		Other
	ENT				Frequent emotional outburst		
	Sinus problems		**Urinary**		Decreased concentration		
	Difficulty chewing		Awakening to urinate		Mood swings		**Gastrointestinal**
	Sores in mouth		Burning		Tendency to hold emotions in		Change of bowel habits
	Dental problems		Frequency		Other		Diarrhea
	Bleeding from ears		Change in urine habits				Frequent use of antacids
	Discharge from ears		Incontinence		**Respiratory**		Indigestion
	Hearing impairment		Blood in urine		Coughing blood		Poor control of bowel
	Ringing in ears		Decreased strength of urine flow		Short of breath		Bloating
	Difficulty swallowing		Other		Difficulty breathing when lying flat to sleep		Constipation
	Tonsils enlarged				Sputum		Gastric reflux
	Other		**Neurological**		Cough		Other
			Numbness		Other		
			Loss of sensation				
			Tingling				
			Other				

Past Medical History

	Breasts		Abdomen		Neurological		Rheumatic
	Breast cancer		Ulcerative colitis		Seizures		Rheumatoid arthritis
	Fibrocystic disease		Hepatitis		Multiple sclerosis		Osteoarthritis
	Other:		Malabsorption syndrome		Neuropathy		Lupus
	Throat		Ulcers		Head injury		Fibromyalgia
	Esophagitis		Cirrhosis		Alzheimer's disease		Gout
	Throat cancer		IBS		Plexopathy		Chronic fatigue syndrome
	Dysphagia		Pancreatitis		Migraine headaches		Other:
	Hiatal hernia		Umbilical hernia		Brain aneurysm		**Reproductive/Urinary**
	Other:		Diverticulosis		Radiculopathy		Uterine cancer
	Lungs		Crohn's disease		Tension headaches		Penile cancer
	Emphysema		Inguinal hernia		Brain cancer		Urinary tract infection
	Cancer		Diverticulitis		Carpal tunnel syndrome		Uterine fibroids and/or polyps
	Pulmonary hypertension		Stomach cancer		Cluster headaches		Testicular cancer
	Asthma		Appendicitis		Parkinson's disease		Pyelonephritis
	Pulmonary embolism		Gastritis		Shingles		Endometriosis
	Bronchitis		Colon cancer		Stroke(s)		Yeast infections
	COPD		Other:		Autism		Bladder cancer
	Pulmonary fibrosis		**Vascular**		Other:		Kidney cancer
	Pneumonia		Poor circulation disorder(s)		**Heart**		Sexually transmitted diseases
	Other:		Foot or leg ulcer		Angina		Prostatitis
	Endocrine		Blood clot to legs		Arrhythmia		Kidney stone(s)
	Diabetes		Raynaud's disease		Hypotension		Cervical cancer
	Hyperthyroidism		Phlebitis		Heart attack		Benign prostatic hypertrophy (BPH)
	Hypothyroidism		Other:		Mitral valve prolapse		Vaginal cancer
	Adrenal disorder		**Mental**		Congestive heart failure		Other:
	Other:		Depression		Hypertension		
			Manic/Depressive (Bipolar)		Other:		
			Schizophrenia				
			Other:				

Social History:

Single Married Divorced Widowed | Right or Left Handed (please circle)

Current work status: (please circle): Full time Part time Restricted Student Retired Unemployed
Not working Temporary disability Permanent Disability Partial Disability

Occupation/Retired from position: | Employer:

Is your present condition due to work related injury? | If so, last date worked:

Children? | Male (ages and health) | Female (ages and health)

What is your religious/spiritual orientation? (optional)

What and when do you drink? How much? Beer Alcohol Wine

Do you use tobacco? Former user? Type?(smoke/chew/vape) How many years?

Risk assessment: please put check mark in boxes next to all that apply

	Family history of alcohol abuse		Personal history of alcohol abuse
	Family history of drug abuse		Personal history of drug abuse
	Family history of prescription drug abuse		Personal history of prescription drug abuse
	Diagnosis of ADD, OCD, bipolar, schizophrenia		Age between 16-45 years old
	Diagnosis of depression		History of pre-adolescent sexual abuse

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Authorization to Discuss Medical Information

If you would like us to be able to release any information to a friend or family member, if they were to call on your behalf, please list that person below. Also, please check the box of what we are allowed to release to that person, as well as if there is any expiration for this release.

Information to be given to: Name:_____

Relationship:_____

Address:_____

Phone:_____

Please check the box of the specific information to be released/discussed:

☐ Appointment Date/Time ☐ Diagnosis ☐ X-ray results

☐ Lab Tests/Results ☐ Summary of Medical Record ☐ Care Plan

☐ Other (specify):_____

Please check the boxes below if you want any of these to remain confidential information:

☐ Mental Health ☐ HIV information ☐ Alcohol/Drug Information

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ (specify expiration date) ☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Rehabilitation Specialists of Monroe the right to discuss my medical information with the person listed above.
- I may refuse to sign this authorization if I choose.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

Relationship to Patient (if signed by personal representative of patient):_____

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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. If you cannot pay your balance in full each month, payment arrangements will need to be made with our billing staff for agreeable payment terms. If a payment plan is established, a payment must be made each month in the agreed upon amount. 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 twenty-five ($25.00) dollar no-show fee. This fee is your responsibility. It will not be billed to your insurance. Patients who have been charged for three late cancel and/or no show fees will be considered for discharge from the practice for non-compliance of their treatment plan.

I have read and understand the above written financial policy.

Signed: _____ Witnessed: _____ Date: _____

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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
905 N. Macomb St., Suite 3
Monroe, MI. 48162

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. **I understand that a fee will be charged for all missed appointments with the doctor or therapist.**

Patient Name:_____/_____
PRINT SIGNATURE

Social Security Number:_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

Witnessed by:_____ Date of Request:_____

Rehabilitation Specialists of Monroe

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. We 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. <u>The right to inspect and copy your protected health information</u>. 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.