P a m e l a   B a r t o n ,   M D
Concierge Medical House Calls

Patient Information Form

Name: ____ Date of Birth: ______________
First Middle Init Last

Address: ____ County: ______________
Street Apt City State Zip

Sex: M F Marital Status ________ Age ________ SS# ________-________-________

Phone: Home ________________ Cell ________________ Fax ________________

Primary Caregiver: ______________________________________ Relationship: ______________

Emergency Contact: ______________________________________ Relationship: ______________

Address ____

Phone: Home ________________ Cell ________________ Fax ________________

Email: ______________________________________ Best way to contact you: ______________

Living Arrangements: Who lives with you? ______________________________________

Language(s) spoken in the home: Primary ____________________ Other ____________________

Pharmacy:______________________ Phone ________________ Fax________________

Primary Care Physician: ______________________ Phone ____________ Fax ____________

Address ____

Other Physicians:

Name: ______________________ Specialty ________________ Reason ____________

Phone ____________ Fax ____________ Address ______________________________

Name: ______________________ Specialty ________________ Reason ____________

Phone ____________ Fax ____________ Address ______________________________

Referred by: ______________________ or, how did you find me? ______________________

Patient Information Form
page 2/2

Patient: ____ Date of Birth: _________________

Primary Insurance Carrier: ____

SUBSCRIBER NAME ___________________________________ RELATION TO PATIENT _______________________________

SUBSCRIBER SS# _____________________________________ SUBSCRIBER DATE OF BIRTH ___________________________

POLICY NUMBER _____________________________________ GROUP# ____

Medicare #: ____ Drug Plan: ____

Secondary Insurance Carrier ____

SUBSCRIBER NAME __________________________________ RELATION TO PATIENT ________________________________

SUBSCRIBER SS# ____________________________________ SUBSCRIBER DATE OF BIRTH ____________________________

POLICY NUMBER: ____________________________________ GROUP # ____

Please provide a photocopy of each side of your insurance card(s) – front and back. Thank you.

I authorize payment of medical benefits to Dr Pamela Barton, MD. I acknowledge that I am responsible for paying the fees associated with the services provided by Dr Barton if my insurance does not cover them.

Name of patient or legal representative ____

Signature ____ Date ______________________________

53 Humbert St . Princeton NJ 08542
609-924-0100

38 West 69th St, #1C . New York NY 10023
212-252-2305

www.DoctorBarton.com . fax 888-386-5394

Fee Schedule & Payment Agreement

HOUSE CALLS:

The fee for a house call is $625. House calls typically last an hour.

Extended time at a visit is billed at $600 an hour in increments of one-tenth of an hour or 6 minutes.

OTHER SERVICES:

Additional services, billed at the rate of $600 an hour in increments of one-tenth of an hour or 6 minutes, may include but are not limited to:

- Communication — phone calls, emails, text messages, & face to face meetings — with:
  - Patient
  - Family members
  - Hired caregivers
  - Pharmacies
  - Laboratories
  - Medical equipment providers
  - Members of the medical team, including current and previous physicians, nurses, therapists
- Document Review
- Fulfillment of research requests
- Document preparation

TRAVEL FEES:

There is no fee for travel in Manhattan. Outside Manhattan, after the first 30 minutes, travel time is billed at the rate of $300 an hour in increments of one quarter of an hour. There is a minimum charge of one quarter of an hour for travel greater than 30 minutes. Additional travel expenses may include taxi & private cars, mileage, transit fees and, in special circumstances, food and lodging.

MEANS OF PAYMENT:

Payment for services will be made by cash or check at the time of service or upon receipt of invoice.

The undersigned have read and agree to be bound by this Agreement.

PATIENT NAME ____________________________________ DATE OF BIRTH ____________________

____ ___________________________
Signature of patient or legal representative Date

____ ___________________________
Pamela Barton, MD Date

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Health History Form

Thank you for taking the time to complete this form as thoroughly as possible. This information allows me to provide the best care possible to my patients. Feel free to use additional pages if necessary.

Patient Name: ______________________________ **Date of Birth**: ______________________________

A. Current/Past Medical Problems. (for example, Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye problems, etc.) **Include approximate date of onset or diagnosis:**

1. ______________________________ ______________________________

2. ______________________________ ______________________________

3. ______________________________ ______________________________

4. ______________________________ ______________________________

5. ______________________________ ______________________________

6. ______________________________ ______________________________

7. ______________________________ ______________________________

B. Past Surgeries. (for example, Gall Bladder removed, Appendectomy, Hysterectomy, Cataract surgery, Prostate surgery, Heart surgery, Angioplasty, Colonoscopy, etc.) **Include approximate date of surgery:**

1. ____________________ __________ **3.** ____________________ __________

2. ____________________ __________ **4.** ____________________ __________

C. Recent Hospitalizations. (In the last 2+ years) **Please provide reason, dates, name of hospital:**

____

____

____

If you have recent test results or other documentation of your medical history, please make them available to me at the first visit.

D. Current Medications.

Name of medicine	Strength	**How many times a day?** When do you take it? AM / PM? With Meals?	**Prescribed by?** (Physician's last name)	Why do you take it?

E. Reactions to medications taken in the past. (for example, Rash, Swelling, Trouble Breathing, etc.)

____

____

F. Family History. Please list medical problems of close family members (for example Dementia, Cancer and what type, Heart disease, Stroke, Diabetes, Hypertension, Depression, etc.).

Mother ______________________ **Father** ______________________

Siblings ____

Other family members ____

G. Review of Systems. Please circle / describe below any of the following symptoms you may be having:

General: Decreased Appetite Fevers or Sweats Chills Insomnia Sleeping more than usual

Height: __________ Any loss of height? _________ inches **Current Weight:** _____________ pounds (OK to estimate)

Weight: loss / gain ___________________ approximately _________ pounds over the past _________ months.

Eyes: Decreased Vision Eye pain Tearing Dry eyes Last eye exam: _______________________________

Ears, Nose, Throat, Mouth: Hearing Loss Hearing Aid Wax in Ears Runny Nose Sinus Problems

Dentures Swallowing problems Pain in Mouth Dry Mouth Last dental exam: __________________

Cardiovascular: Chest pain Need to sleep sitting up to be comfortable Leg pain when walking

Respiratory: Shortness of breath Cough, describe ____ Wheezing

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Abdominal pain Heartburn Blood in stool

Incontinent of stool? Never Sometimes Always I typically move my bowels every _______ day(s)

Genitourinary: Urinary frequency Urgency Burning Intermittently losing urine or wetting pants

Completely incontinent of urine Nighttime urination episodes _____ x per night

Reproductive (for women): Number of pregnancies _______________ Number of live births ________________

Musculoskeletal: Joint pain (Location:_____________________) Joint swelling (Location:____________________)

Weakness? arms legs other One sided weakness from stroke

Skin: Bed sore (Location of bedsore and type of dressing: ____)

Rash (Location: _______________________________________) Other Skin Problem _________________________________

Neurologic: Seizures Falling Memory loss Confusion Numbness Dizziness Tremor Paralysis

Psychiatric: Depression Anxiety Lack of motivation Suicidal thoughts Delusions

Hallucinations "Sundowning" Irritability Threatening Behavior

Endocrine: Diabetes Vitamin D deficiency Thyroid Disorder Heat or cold intolerance Hot flashes

If diabetic, how many times a day glucose checked: _____ Morning glucose range: ________ Evening glucose range: ________

Hematology/Lymphatics: Easy bruising Leg or other swelling Anemia Other _____________________

Allergy/Immunology: Environmental Allergies Hay fever Allergies to foods

Any other problems not mentioned above? ____

H. Social History.

Marital Status: married separated widowed divorced in a long term relationship single, never married

Past or Current Occupation(s): ______________________________ **Spouse's Occupation:** ____________________

Education Level: grade school high school GED college advanced degree ______________________

Transportation: How often and for what purpose do you leave the house? ____________________________________

Tobacco: No (never smoked) No (year quit ____________) Yes (current smoker) How much? ________________

Alcohol: No Yes, describe alcohol usage ______________________ History of drug or alcohol problem? Yes No

Religion: ____ Is your faith important to you? Yes No

I. Immunizations. Please list dates if known.

Immunization History				**Date**
Influenza (Flu)	Unsure	No	**Yes**	________________
Pneumococcal	Unsure	No	**Yes**	________________
Tetanus	Unsure	No	**Yes**	________________
Chicken Pox	Unsure	No	**Yes**	________________

J. Activities of Daily Living. Please mark or fill in the appropriate box below:

Activity of Daily Living	**No Assistance**	**Total Assistance**	**Needs some partial assistance. Please describe:**
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

K. Home Health Agency: No Yes **Name:** ____

Visiting Nurse: No Yes **Social Worker:** No Yes **Physical or Occupational Therapy:** No Yes

L. Durable Medical Equipment. Please list any medical equipment you have in the home such as a bedside commode, wheel chair, walker, hospital bed, tube feeding pump, suction machine, etc:

____

____ Supplier: ____

M. Hospital. If you need to be hospitalized, which hospital(s) do you prefer? ______________________________

N. Advance Directives. Do you have a . . .

Health Care Proxy? No Yes ____
Name Relationship

MOLST Form (Medical Orders for Life Sustaining Treatment (New York))? No Yes Unsure

POLST Form (New Jersey Practitioner Orders for Life Sustaining Treatment)? No Yes Unsure

Living Will? No Yes Unsure

DNR (Do Not Resuscitate) Form? No Yes Unsure

Documentation of Oral Advance Directive? No Yes Unsure

If you have any of the above documents please have a copy made to be placed in your medical chart.

What are the main concerns you would like to have addressed at the first visit?

____

____

____

____

____

____

____ ______________
Signature of patient or legal representative Date

Pamela Barton, MD
Concierge Medical House Calls

Release of Information Form

Patient's Name: ______________________________ Date of Birth: ____________________

I, the above named person (or the person's legal guardian) request the following physician or health care facility to release my health care information to Pamela Barton, MD.

Name of Physician or Facility: ____

Address: ____
Street City State Zip Code

Phone: ______________________________ Fax: ______________________________

This request and authorization applies to:

☐ All health care information

☐ Health care information relating to the following treatment, condition or dates: ____________________

____

____

☐ Other: ____

Name of patient or legal representative: ____

Signature: ______________________________________ Date: ____________________

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OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Pamela Barton, MD 38 West 69th Street, #1C New York NY 10023

9(a). Specific information to be released:

❑ Medical Record from (insert date) ___________________ to (insert date) ___________________

❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

❑ Other: ___________________________________

____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here ____________ I authorize ____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________________ Date: ____________________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Private Contract for Medicare Beneficiaries

The Balanced Budget Act of 1997 (Section 1802(b) of the Social Security Act) allows physicians who have opted out of Medicare to enter into a private contract with Medicare beneficiaries. When signed by you or your legal representative below this will become such a private contract.

The opt-out law has strict requirements, including my informing you that I am not excluded from the Medicare program (under Section 1128 of the Social Security Act). You or your legal representative must sign the private contract in advance of the first service. At that time you must not be facing an emergency or urgent healthcare situation.

The law mandates that the contract include the provisions listed below. Please read this entire contract carefully and ask me any questions you may have before you sign it. By signing, you understand, agree, and expressly acknowledge all of the terms:

1. You agree that you will not submit a claim or ask me to submit a claim for payment under Medicare for my services, even if such services would otherwise be covered by Medicare. This means that you agree not to bill Medicare or ask me to bill Medicare. This also means that you will give up Medicare coverage of, and payment for, services furnished by me because I have opted out of Medicare.

2. You acknowledge that Medigap insurance plans do not, and other supplemental insurance plans may not, make payments for services furnished by me while this contract is in effect because payment for my services will not be made by Medicare.

3. You agree to be fully responsible for payment of services provided by me. You acknowledge that no reimbursement will be provided by Medicare to you or to me for services provided by me. You acknowledge that I am not limited in the amount that I may charge you, either more or less, for the services that I provide to you. This means that any fee limit or Medicare reimbursement regulations that would otherwise be imposed by Medicare will not apply to the amount that I may bill for services I furnish. The amount may be more or less than Medicare would allow.

4. You acknowledge that you have the right to have services provided by other physicians or practitioners. You understand that you still have the right to obtain Medicare-covered services from physicians and healthcare practitioners who have not opted out of Medicare.

After signing this contract all other Medicare-covered services will still be available to you from other physicians or practitioners who have not opted out of Medicare. You may use the services of those physicians or practitioners even after you enter into this private contract with me.

By signing below, you acknowledge that you have read this in its entirety, and that you have had an opportunity to review the terms of this contract and to discuss them with me and anyone else of your choice. A copy of this private contract will be provided to you after it has been signed by both of us.

PATIENT NAME ____ DATE OF BIRTH _______________________

ACCEPTED AND AGREED TO:

____ ______________________________

Signature of patient or legal representative Date

____ ______________________________

Pamela Barton, MD Date

Pamela Barton, MD
Concierge Medical House Calls

53 Humbert St . Princeton NJ 08542
609-924-0100

38 West 69th St., #1C . New York NY 10023
212-252-2305

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ("PHI") ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Dr Barton at 609-924-0100 or 212-252-2305.

My OBLIGATIONS:

I am required by law to:

- Maintain the privacy of Protected Health Information (hereafter "PHI")
- Give you this notice of my legal duties and privacy practices regarding your PHI
- Follow the terms of current Notice of Privacy Practices

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways I may use and disclose your Protected Health Information ("PHI"). Except for the purposes described below, I will use and disclose your PHI only with your written permission. You may revoke such permission at any time by writing to me.

For Treatment. I may use and disclose your PHI for your treatment and to provide you with treatment-related health care services. For example, I may disclose your PHI to doctors, nurses, technicians, or other personnel, including people outside my office, who are involved in your medical care and need the information to provide you with medical care.

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

For Health Care Operations. I may use and disclose your PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of my patients receive quality care and to operate and manage my office. For example, I may use and disclose your PHI to make sure the care you receive is of the highest quality. I may share your PHI with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I also may use and disclose your PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, I may share your PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. I also may

notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, I may use and disclose your PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before I use or disclose your PHI for research, the project will go through a special approval process. Even without special approval, I may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

SPECIAL SITUATIONS:

As Required by Law. I will disclose your PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. I may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. I may disclose your PHI to business associates who perform functions on my behalf or provide me with services if the information is necessary for such functions or services. For example, I may use another company to perform billing on my behalf. All of my business associates are obligated to protect the privacy of your PHI and are not allowed to use or disclose any information other than as specified in my contract.

Organ and Tissue Donation. If you are an organ donor, I may use or release your PHI to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, I may release your PHI as required by military command authorities. I also may release your PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. I may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. I may disclose your PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if I believe a patient has been the victim of abuse, neglect or domestic violence. I will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. I may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. I may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, I may disclose your PHI in response to a court or administrative order. I also may disclose your PHI 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 the information requested.

Law Enforcement. I may release your PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I am unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct; (5) about criminal conduct on my premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. I may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I also may release your PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities. I may release your PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. I may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release your PHI to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE ME TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT-OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment.

Disaster Relief. I may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. I will provide you with an opportunity to agree or object to such a disclosure whenever I practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of your PHI for marketing purposes; and

2. Disclosures that constitute a sale of your PHI

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to me will be made only with your written authorization. If you do give me an authorization, you may revoke it at any time by submitting a written revocation to me and I will no longer disclose your PHI under the authorization. But disclosure that I made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding PHI I have about you:

Right to Inspect and Copy. You have a right to inspect and copy your PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes.

To inspect and copy your PHI, you must make your request in writing to me. I have up to 30 days to make your PHI available to you and I may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. I may deny your request in certain limited circumstances. If I do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. I will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either my standard electronic format or, if you do not want this form or format, a readable hard copy. I may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend. If you feel that the PHI I have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my office. To request an amendment, you must make your request in writing to me.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures I made of your PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to me.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI I use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI I disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that I not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to me. I am not required to agree to your request unless you are asking me to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and the information you wish to restrict pertains solely to a health care item or service for which you have paid me "out-of-pocket" in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, if you have requested that I not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.

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

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at my web site, www.DoctorBarton.com.

CHANGES TO THIS NOTICE:

I reserve the right to change this notice and make the new notice apply to the PHI I already have as well as any information I receive in the future. I will post a copy of my current notice on my website. The notice will contain the effective date on the first page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints filed with me must be made in writing. You will not be penalized for filing a complaint.

I have read and understood the Notice of Privacy Practices of Pamela E. Barton, MD

PATIENT NAME ____ DATE OF BIRTH ________________________

____ ________________________________

Signature of patient or legal representative Date