AUNT MARTHA'S HEALTH CENTER

Aunt Martha's Health Center
Patient Registration Form

Insurance:
- ☐ Medicaid
- ☐ Medicaid-*Illinois Health Connect*
- ☐ Harmony/HMO
- ☐ Private Insurance/PPO
- ☐ None
- ☐ Other_____

PATIENT INFORMATION

Today's Date	Last Name	First Name	Middle

Date of Birth	Age	Gender: ❑ Female ❑ Male

Address	City	State	Zip Code

Primary Language:

S.S.# ___ ___ ____

AMHC ID # A___ ___ ____

Marital Status: ❑ Divorced ❑ Single ❑ Legally Separated ❑ Unknown ❑ Life Partner ❑ Widowed ❑ Married

Home Phone Number: (____)_____
Can we leave a message? ❑ No ❑ Yes

Daytime Phone Number: (____)_____
Can we leave a message? ❑ No ❑ Yes

Alternate Phone Number: (____)_____
Can we leave a message? ❑ No ❑ Yes

Contact Preference:
- ❑ Home Phone
- ❑ Daytime Phone
- ❑ Alternate Phone
- ❑ No Phone Contact
- ❑ **EMAIL:**_____

If the patient is in 8th grade or under, please indicate School District # and School Name. If not, indicate N/A.
❑ 8th grade and under School District # School Name:
❑ N/A

Is the patient enrolled in Illinois Health Connect?
❑ No ❑ Yes ❑ Unsure (Need clarity from Registration Staff)

SPECIAL NEEDS / ADDITIONAL DEMOGRAPHIC INFORMATION

Do you have any of the following impairments?
Impairments
Sight ❑ No ❑ Yes
Sound ❑ No ❑ Yes
Verbal ❑ No ❑ Yes
Recent Trauma ❑ No ❑ Yes

Educational Mechanism
Verbal instructions given
Written instructions given

Special Religious Concerns
❑ No ❑ Yes
If yes, please explain:
_____

Homeless Status: ❑ Not Homeless ❑ Shelter ❑ Transitional ❑ Doubling Up ❑ Street ❑ Unknown

Migrant Worker Status: ❑ Not a farm worker ❑ Seasonal ❑ Migrant

Language Barrier: ❑ No ❑ Yes

Veteran Status: ❑ No ❑ Yes

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian ❑ Other Pacific Islander ❑ White

Ethnicity: ❑ Latino/Hispanic ❑ Non Hispanic ❑ Unknown Ethnicity

How did you hear about our services? (check all that apply)
❑ Flyer ❑ Sign ❑ Radio ❑ T.V. ❑ School ❑ Health Fair ❑ Billboards
❑ Mailing ❑ Church ❑ Presentation ❑ Phone Book ❑ Family/Friend ❑ Internet/Website
❑ Current Patient ❑ Dr._____ ❑ Insurance Plan _____
❑ Hospital _____ ❑ Social Services Agency _____
❑ Aunt Martha's Employee _____

EMERGENCY CONTACT / RESPONSIBLE PARTY

Emergency Contact Name | Phone Number | Relationship

Parent/Legal Guardian/Responsible Party: **IF SAME AS PATIENT, please check box** ☐

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Primary Phone Number _____ Alternate Phone Number _____

Last Name _____ First Name _____ Middle _____ Previous Last Name _____

Date of Birth ____/____/____ Age _____ Relationship to Pt. _____ Gender: ☐Male ☐Female

Address _____ City _____ State _____ Zip Code _____ County _____

INSURANCE INFORMATION / INCOME VERIFICATION

(Please show your insurance card and picture identification to the receptionist)
(Income verification is requested for all patients, regardless of insurance status)

Person Responsible for Bill: **IF SAME AS PATIENT, please check box** ☐
Is this person a patient here? ☐ No ☐ Yes Is this person covered by insurance? ☐ No ☐ Yes

Last Name _____ First Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____

Primary Phone Number _____ Alternate Phone Number _____

Please indicate primary insurance:
☐ Medicaid
☐ Medicaid – Illinois Health Connect
☐ Harmony / HMO
☐ Private Insurance / PPO
☐ None

Policy Holder's Name _____ Policy/Recipient ID # _____

$_____ Co-Pay Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance (if applicable) _____ Policy/Recipient ID# _____

Policy Holder's Name _____ Relationship to Patient _____

Family Size: _____ Family Combined Income: $_____ Per Hour / Week / Month / Year

Annualized Income: $_____

OFFICE USE:

Income Documentation On File: ☐ No ☐ Yes Financial Waiver Signed: ☐ No ☐ Yes ☐ N/A

Income Re-Certify Date: _____ Staff Signature: _____

Authorization:
I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits to myself or the party who accepts assignment.

X _____ _____
Signature of Patient / Parent or Legal Guardian **Date**

AUNT MARTHA'S HEALTH CENTER

SLIDING FEE APPLICATION

For your assistance, we have a sliding fee discount program. In order for us to determine if you qualify, please provide us with the following information.

Parent/Guarantor Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____

Employer: _____ Employer Phone: _____

Employer Address: _____

HOUSEHOLD INCOME: *The income of all household members must be reported and counted.*

How many people are supported by this income? _____

Use the number of persons who live in the same household and who share income, food and rent. That number may include you, your spouse, and/or any dependents.

Indicate all source(s) of income for your household. Please check all that apply.

Wages and Salary		Striker Benefits	
Unemployment		Public Assistance	
Self-employment		Child Support	
Social Security / SSI		Veteran's Benefits	
Pension Funds		Alimony	
Workers' Compensation		Other Income (please specify)	

TOTAL ANNUAL GROSS INCOME $ _____ (Gross income is before taxes and deductions)

All sources of income must be documented. Depending on your source of income, at least one of the following documents is required with this application:

1. 2 paycheck stubs (most recent for wages)
2. Benefit statement
3. Bank statement (for direct deposit payments)
4. Court orders or other documents

If I have not supplied **proof of income** today, I will do so within **30 days** or be subject to the **full charge** for all services.

I certify that the information I have provided on this application is true and accurate and I acknowledge it is subject to further verification.

_____ _____

Signature of Responsible Party Date

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

PATIENT NUMBER

HEALTH HISTORY

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐ ☐	☐ ☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. DO YOU USE TOBACCO	☐	☐
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
15. ARE YOU WEARING CONTACT LENSES	☐	☐
16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐

	YES	NO
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

PATIENT NUMBER

AUNT MARTHA'S HEALTHCARE NETWORK
DENTAL CONSENT

Patient's Name:_____ DOB:_____

I hereby consent to receive dental services form Aunt Martha's Youth Services, Inc. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my dental history or treatment will remain confidential unless disclosure is required under existing state and federal laws.

I have been given a copy of a copy of my client rights and responsibilities and the agency rules and regulations. By signing below, I acknowledge that I have received a copy of, read understood my client rights and responsibilities.

_____ _____
Patient's signature (12 years and older) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Witness Signature Date

AUNT MARTHA'S HEALTHCARE NETWORK
Dental Clinic
Patient Responsibility Form

As a dental patient receiving care at the Aunt Martha's Healthcare Network (AMHN) Dental Clinic you are responsible for coming to your appointment on time.

LATE ARRIVALS

If you arrive more than 15 minutes past your appointment time, it is up to the discretion of the Dentist to see you or to have you reschedule your appointment.

CANCELLATIONS

If you cannot come to your scheduled appointment, please call the dental clinic you have an appointment with during office hours at least one day prior to the appointment. This allows us to fill the time with another patient who has been waiting for care.

CHILDREN UNDER 18 YEARS OF AGE

A parent or legal guardian must come with the children for appointments to receive care unless prior signed consent has been given. This consent is good for one year.

FAILED APPOINTMENTS

If you do not come to a dental appointment, cancel with less than 24-hour notice, or arrive after the allowable 15 minutes, it will be registered in your record as a missed appointment.

If you miss two (2) appointments in a twelve month period, whether by (a) not coming, (b) being late or (c) canceling with less than 24-hour notice, YOU WILL NOT BE GIVEN ANY FURTHER APPOINTMENTS FOR A SIX (6) MONTH PERIOD.

If after this six (6) month period one (1) appointment is missed, NO FURTHER APPOINTMENTS WILL BE SCHEDULED.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Witness

AUNT MARTHA'S HEALTHCARE NETWORK
CLIENT'S RIGHTS AND RESPONSIBILITIES

Aunt Martha's Youth Service Center is dedicated to providing clients with the best possible care to meet their identified needs. To accomplish this, we believe it is critical to include our clients and parents/legal guardians, when applicable, in all decisions that directly impact treatment.

It is the duty of Aunt Martha's staff to inform you of your rights and program responsibilities before the commencement of services in a language or method of communications that you will understand. These rights are protected and promoted by agency staff.

- ✓ You have the right to Confidentiality of information which is governed by the Health Insurance Portability and Accountability Act of 1996 and state law where applicable. Your personal information will be used only as described in the Notice of Privacy Practices, unless written authorization is given to you or your legal guardian, if applicable, except as required by law. If written permission is granted, you have the right to know what is contained in the information shared.
- ✓ You have the right to be informed of the nature, availability (including hours which care is available) and goals of all services to which you are entitled through the agency or other resources.
- ✓ You have the right to receive services with adequate and human care in the least restrictive environment
- ✓ You have the right to receive services regardless of age, sex, race, religious belief, ethnic origin, or impairment. However, if you are under the age of 18, your parent or legal guardian's permission in needed.
- ✓ You have the right to be free from abuse, neglect, or exploitation. You will not be subjected to any type of punishment that violates your rights such as corporal punishment, ridicule, humiliation, verbal abuse, or any other means of discipline which would lessen your sense of dignity and value as a person.
- ✓ You have the right to view your client record and examine its contents in the presence of a staff member qualified to interpret the file contents. You may request that a statement of clarification be included in your record should you find any discrepancies.
- ✓ You or your legal guardian have the right to file a grievance or appeal decisions of the provider up to and including the executive director or comparable position and be informed of the outcome of the petition.
- ✓ You or your guardian has the right to refuse services, including medications. You will be informed of alternative services available and the risks of such alternatives, if any, as well as the possible consequences of refusal of such services.
- ✓ Treatment and/pr services will not be denied, reduced, suspended, or terminated for exercising any of your rights.
- ✓ You will be made aware of any fees or payment policies that pertain to the services provided. In clinical programs, an inability to pay will not be the sole determining factor in your admission or discharge from any services.
- ✓ You have the right and responsibility to be involved in any and all care decisions.
- ✓ You have the right to be informed about any financial incentive programs related to your care, treatment or services.
- ✓ You have the responsibility to provide relevant information to clinic staff and to the physician or medical provider to the ex that you are able.
- ✓ You have the responsibility to ask questions if you don't understand instructions that you are given.
- ✓ You have the responsibility to accept consequences that may occur as a result of decisions that you make, actions that you take, or inaction.
- ✓ You have the responsibility to follow rules and regulations specific to our facility.
- ✓ You have the responsibility to show respect to other patients and staff.
- ✓ You have the responsibility to make an effort to pay treatment related bills for which you are responsible.

NOTICE OF PRIVACY PRACTICES

Aunt Martha's Youth Service Center, Inc. is a covered entity under HIPAA (Health Insurance Portability and Accountability Act). As covered entity, Aunt Martha's is committed to ensuring that your private health information is treated confidentially. This notice describes instances when your health information may be disclosed (used outside of Aunt Martha's). Other than the disclosures described in this notice, your health information will not be disclosed without your signed authorization.

Use of Information for Treatment, Payment and Operations

1. In order to provide good medical care to you (treatment), obtain payment for services (payment), and ensure quality and efficiency in our day functioning (operations), there will be times when we must share information outside of this organization.
    a. An example which may occur under treatment would be calling a physician or hospital to which we are referring you and providing them with information about your condition.
    b. For payment purposes, we might send information to your insurance company, required in order to process your bill.
    c. For operations, we might allow your chart to be reviewed by an external reviewer or auditor.
2. In the above instances, your personal health information may be disclosed. Under each of these circumstances, the entities that review your information will be either bound by federal law or otherwise have a responsibility to keep your personal information confidential.
3. Information that we may release under these circumstances would not be limited and could include information regarding HIV infection, substance abuse, and/or psychiatric illness.
4. You may request restrictions beyond those stated in this notice but our organizations is not required to abide by the restrictions requested unless we agree to do so.

The Right to Inspect and Amend Records

- You have the right to inspect your medical/client record or any other document owned by Aunt Martha's that contains your personal health information with rare exceptions.
- If you believe that any of the information inspected is inaccurate, you have the right to request that the information is changed so that is accurate.
- A request to inspect or amend your health information must be made in writing. Should you make such a request, it will be evaluated by Aunt Martha's privacy officer or designee to determine if the request to inspect your health information and/or the requested change in your health information should be allowed.
- You will be informed of a decision (for inspection or amendment/change of record) within a reasonable time period.
- If a decision is made to change the information as requested, the change will be made an effort will be made to inform other entities who may receive inaccurate information.
- However, if it is determined that no change is warranted, you will be informed of this decision as well. You may appeal this decision by resubmitting your request for the change in writing and stating in that request that you are now appealing a previous decision.
- Upon receipt of the second request, the records will be reevaluated by a licensed physician who was not involved in your treatment or in the decision to deny the initial request. The decision at this second level of review will be final.

Disclosure for Research

- It is possible that your health information might be accessed by a researcher.
- Such access will not be allowed under any circumstances unless the researcher that clearly demonstrated that your health information will be treated confidentially and that protective measures are put in place to ensure that unauthorized access does not occur.

- In these situations, if feasible, you will be contacted and your permission will be asked to allow your information to be utilized for this purpose.
- Whether you allow or don't allow your information to be used, your services at Aunt Martha's will not be affected. Your treatment will in no way be conditioned upon your approval.
- In situations where it is not feasible to obtain your approval, your information may still be used (but not in instances where you have requested that your information not be used) provided that the researcher has demonstrated that appropriate steps will be taken to protect your identity, that protective measures are in place to prevent unauthorized access, and that any information pertaining to your identity will be destroyed as early in the research as possible.
- Because of strict protection afforded your identity, Aunt Martha's may not be known definitively if your information is used for this purpose. If there is any possibility that such a use may have occurred, Aunt Martha's will provide you with that information upon occurred, Aunt Martha's will provide you with that information upon request including information on how to contact the researchers and information regarding what information was collected, how the information was used, and how confidentiality was maintained.
- Any disclosure beyond that described above will generally require you to sign and authorization form except under rare and extenuating circumstances.
- Aunt Martha's has formed a Corporate/HIPAA Compliance Committee which is responsible for overseeing the implementation of Aunt Martha's HIPAA compliance efforts and ensuring that your personal health information is treated confidentially. Members of the committee, including those who are responsible for investigating complaint, are listed below.

General Manager	Raul Garza
Medical Director	Jennifer Byrd
Complaint Recipient	Jill Eitel

- You may submit a complaint verbally or in writing to either complaint recipient at any of the above locations. If you have a voice mail message, include your name, patients/client's name and details about the complaint.
- Furthermore, at your discretion, you may complain to any members of the committee listed above. Additionally, if you believe that your rights to privacy have been violated, you have the right to complain to the Secretary of the Department of Health and Human Services in the Office of Civil Rights.
- This privacy notice may be subject to change. If a change should occur, the change will be posted in our waiting area and on our web site at the time of implementation or as soon as possible after implementation. You may request a current notice at any time verbally or in writing.