



Aunt Martha's Health Center
Patient Registration Form – WOMEN'S HEALTH (OB-GYNE)

NextGen Record # _____

PATIENT INFORMATION			
Today's Date	Last Name	First Name	Middle
Date of Birth	Age	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address		City	State Zip Code
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		Do you have Advance Directives for Health Care? (i.e., Living Will or Power of Attorney) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Sure	
Social Security Number: _____ - _____ - _____		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed	
Home Phone Number: (____) _____ May we leave a message at your home phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No Daytime Phone Number: (____) _____ May we leave a message at your daytime phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No Alternate Phone Number: (____) _____ May we leave a message at your alternate phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Contact Preference: <input type="checkbox"/> Home Phone <input type="checkbox"/> Daytime Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> No Phone Contact	
If the patient is in 8th grade or under, please indicate School District # and School Name. If not, indicate N/A. <input type="checkbox"/> 8 th grade and under <input type="checkbox"/> N/A School District # _____ School Name: _____			
Is the patient enrolled in Illinois Health Connect? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure (Need clarity from Registration Staff)			
SPECIAL NEEDS / ADDITIONAL DEMOGRAPHIC INFORMATION			
Do you have any of the following impairments? Sight <input type="checkbox"/> No <input type="checkbox"/> Yes Sound <input type="checkbox"/> No <input type="checkbox"/> Yes Verbal <input type="checkbox"/> No <input type="checkbox"/> Yes Recent Trauma <input type="checkbox"/> No <input type="checkbox"/> Yes		Educational Mechanism Verbal instructions given Written instructions given	
		Special Religious Concerns <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: _____	
Homeless Status: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Unknown			
Migrant Worker Status: <input type="checkbox"/> Not a farm worker <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant			
Language Barrier: <input type="checkbox"/> No <input type="checkbox"/> Yes		Veteran Status: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White		Ethnicity: <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unknown Ethnicity	
How did you hear about our services? (check all that apply) <input type="checkbox"/> Flyer <input type="checkbox"/> Sign <input type="checkbox"/> Radio <input type="checkbox"/> T.V. <input type="checkbox"/> School <input type="checkbox"/> Health Fair <input type="checkbox"/> Billboards <input type="checkbox"/> Mailing <input type="checkbox"/> Church <input type="checkbox"/> Presentation <input type="checkbox"/> Phone Book <input type="checkbox"/> Family/Friend <input type="checkbox"/> Internet/Website <input type="checkbox"/> Current Patient <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan _____ <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Social Services Agency _____ <input type="checkbox"/> Aunt Martha's Employee _____			

EMERGENCY CONTACT

Emergency Contact Name _____ Phone Number _____ Relationship _____
 ()

RESPONSIBLE PARTY

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

Mr. Miss Mrs. Ms.

 Last Name First Name Middle Previous Last Name
 Date of Birth ____/____/____ Age ____ Relationship to Pt. _____ Gender: Male Female

 Address City State Zip Code County

() ()
 Primary Phone Number Alternate Phone Number

INSURANCE INFORMATION

Please show your insurance card and picture identification to the receptionist. Income verification is required 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

• PRIMARY INSURANCE

Please indicate primary insurance:

Medicaid Medicare Illinois Health Connect Harmony / HMO Private Insurance / PPO None

 Policy Holder's Name Policy/Recipient ID #

\$ _____ Patient's Relationship to Policy Holder: Self Spouse Child Other _____

Co-Pay / Deductible

• SECONDARY INSURANCE

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

 Policy Holder's Name Relationship to Patient

INCOME VERIFICATION / HEAD OF HOUSEHOLD FAMILY SIZE / INCOME

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

OFFICE USE ONLY:Signature Forms

Patient Registration Form is Signed and Dated: YES NO
 Medical Consent/HIPAA is Signed and Dated: YES NO

Sliding Fee Forms (Uninsured Patients)

Sliding Fee Application: YES NO N/A
 Current Income Documentation : YES NO N/A
 Current Financial Waive: YES NO N/A
 Slide has been assigned: YES NO N/A

Income Re-Certify Date: _____ Staff Signature: _____

Authorization: With my signature I certify that all of the information provided on the patient registration forms is correct to the best of my knowledge. I authorize the release of any medical or other pertinent information necessary to process claims pertaining to Aunt Martha's Health Center visits.

X _____
 Signature of Patient / Parent or Legal Guardian

 Date



AUNT MARTHA'S HEALTH CENTER
Consent for Medical Services

Patient Name: _____ Date of Birth: _____

I hereby consent to receive medical services from Aunt Martha's Health Center. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws. I consent to the release of my medical history and care to Medicaid, Medicare, Insurance companies, Reviewing and Accreditation Organizations and other Aunt Martha's programs.

_____	_____
Patient Signature	Date
_____	_____
Parent/Guardian/Representative Signature	Date
_____	_____
Staff Witness Signature	Date

**Receipt of Advance Directives Information,
Client's Rights and Responsibilities and Notice of Privacy Practices**

By signing below, I acknowledge that Aunt Martha's has provided me with a copy of an *Introduction to Advance Directives, Clients Rights and Responsibilities and Notice of Privacy Practices*. I have received my copies, I have read and understand the information provided to me.

_____	_____
Patient Signature	Date
_____	_____
Parent/Guardian/Representative Signature	Date
_____	_____
Staff Witness Signature	Date.



PATIENT HEALTH QUESTIONNAIRE

Nine Symptom Depression Check List (For patients ages 11 and older)

Patient Name: _____ Date: _____

1. Over the **last two weeks**, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way **	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

****If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor or Health Care Clinician. If these kinds of thoughts happen when no one is available, go to a hospital emergency room, or call 911.**

2. If you have checked off **any** problem on this questionnaire so far, how **difficult** have these problems made it for you to work, take care of things at home, or get along with people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

(For Clinic Staff Only)	Add columns: _____ + _____ + _____
Total # of Symptoms: _____	Total Score: _____

Staff Signature: _____ Date: _____

Provider Signature (if applicable): _____ Date: _____



DENTAL HEALTH ASSESSMENT

Name: _____

Today's Date: _____

Phone Number: _____

Date of Birth: _____

In order for Aunt Martha's to provide you quality health care, we need to know about you. Please answer the following questions honestly. Check the appropriate box for each question.

- When is the last time you had a dental exam?
 Less than 6 months ago
 6 months – 1 ½ years ago
 More than 1 ½ years ago
 I don't know
- When is the last time you had your teeth cleaned?
 Less than 6 months ago
 6 months – 1 ½ years ago
 More than 1 ½ years ago
 I don't know
- Do your gums bleed when you brush your teeth?
 Yes
 No
 I don't know
- Do you have pain in your mouth?
 Yes
 No
 I don't know

ASESORAMIENTO DE SALUD DENTAL

Nombre: _____

Fecha de hoy: _____

Número de teléfono: _____

Fecha de nacimiento: _____

Para que Aunt Martha's pueda proveerle calidad en su atención médica, por favor conteste las siguientes preguntas con honestidad. Marque la respuesta para cada pregunta.

- ¿Cuándo fue la última vez que usted tuvo un examen dental?
 Menos de 6 meses
 6 meses – 1 ½ años
 Mas de 1 ½ años
 No sé
- ¿Cuándo fue la última vez que usted tuvo una limpieza de dientes?
 Menos de 6 meses
 6 meses – 1 ½ años
 Mas de 1 ½ años
 No sé
- ¿Sus encías sangran cuando se cepilla los dientes?
 Sí
 No
 No sé
- ¿Tiene usted dolor en la boca?
 Sí
 No
 No sé

For office use only

Reviewed by: _____
Signature

_____ Date

Referred? Yes No



AUNT MARTHA'S HEALTH CENTER
INITIAL HEALTH ASSESSMENT

Date:	Name:		
Phone#:	DOB:	Age:	

How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional

- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained fatigue/weakness

Eyes

- Change in vision

Ears/Nose/Throat/Mouth

- Difficulty hearing/ ringing in ears
- Hay fever/allergies/congestion
- Trouble swallowing

Cardiovascular

- Chest pains/discomfort
- Palpitations
- Short of breath with exertion

Breast

- Breast lump
- Nipple discharge

Respiratory

- Cough/wheeze
- Coughing up blood

Gastrointestinal

- Heartburn/reflux
- Blood or change in bowel movement
- Nausea/vomiting/diarrhea
- Pain in abdomen

Genitourinary

- Painful/bloody urination
- Leaking urine
- Nighttime urination
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sexual functions

Musculoskeletal

- Muscle/joint pain
- Recent back pain

Skin

- Rash
- New or change in mole

Neurological

- Headaches
- Memory loss
- Fainting

Psychiatric

- Anxiety/stress
- Sleep problem

Blood/Lymphatic

- Unexplained lumps
- Easy bruising/bleeding

Endo

- Cold/heat intolerance
- Increase thirst/appetite

PERSONAL MEDICAL HISTORY:

Do you have any of the following problems?

- Acid reflux (heartburn)
- Alcoholism/other addiction
- Allergies (environmental)
- Anxiety
- Asthma
- Atrial fibrillation
- Cancer (specify type _____)
- Coagulation (bleeding or clotting) problem
- Cholesterol problem
- Chronic low back pain
- Depression
- Diabetes mellitus
- Erectile dysfunction
- Heart disease (specify type _____)
- Hypertension (high blood pressure)
- Irritable bowel syndrome
- Migraines
- Osteopenia or Osteoporosis
- Prostate problem
- Thyroid problem
- Other problems (please list): _____

Have you ever had any of the following problems? If so, please provide approximate year:

Cancer of _____ Heart attack _____ Blood transfusion _____
 Please specify _____ Stroke (CVA) _____ Seizure _____

SURGICAL HISTORY: Please list all prior operations and dates. I have had no prior surgery.

Operation	Date

Operation	Date



AUNT MARTHA'S HEALTH CENTER
INITIAL HEALTH ASSESSMENT
(continued)

Name: _____	DOB: _____
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REPRODUCTIVE HISTORY:

MENSTRUAL HISTORY

Age when periods started: _____ years. Number of days between periods: _____ days.
 Period duration: _____ days of bleeding. Flow: Light Med Heavy
 Date of last menstrual period: _____ Certainty of last period: Sure Unsure
 Method of birth control: Condoms Pills: Name _____ IUD Depo-Provera
 Nuva Ring Implanon Diaphragm Tubes tied Ortho Evra Patch
 Breakthrough bleeding? Yes No Do you pass clots? Yes No
 Mood swings around time of period? Yes No Previous diagnosis of: Polycystic Ovaries Endometriosis

ARE YOU ARE POST-MENOPAUSAL? Yes No

Age at menopause: _____ years.
 Hormone replacement therapy ever? No Yes Type: _____ # of years: _____ Hot flashes? Yes No

ANY PREGNANCY HISTORY INCLUDING TUBAL & MISCARRIAGE

of total pregnancies: _____ Full-Term Premature # of miscarriages: _____ # of abortions: _____
 Tubal pregnancy? Yes No # of multiple pregnancies (twins): _____ # of C-Sections: _____ # of living children: _____

PAP HISTORY

Date of last PAP: _____ Normal? Yes No
 Any abnormal PAPs? Yes No Date and treatment: _____
 Where was PAP done? _____
 Did your mother take DES while pregnant with you? Yes No I Do Not Know

SOCIAL HISTORY:

Job Title: _____ Marital Status: Single Married Divorced
 Widowed Separated Engaged
 Exercise: No Yes Active, but no formal exercise Heavy, 4 or more times per week Moderate, 1-3 times per week
 Minimal Sedentary
 Tobacco use: Yes No Type: _____ # per day _____ for _____ years. Quit? Yes When _____
 Alcohol use: Yes No Type: _____ # per day _____ for _____ years. Quit? Yes When _____
 Illegal substance abuse: Yes No Type: _____ Frequency _____ for _____ years.
 Quit? Yes When _____
 Caffeine use: (tea, coffee, soda) Yes No Type: _____ # per day _____ for _____ years.

Are you sexually active? Yes No Age of first encounter: _____
 Has anyone ever forced you to have sex? Yes No if **yes**, please describe: _____

Have you had sex without protection because your partner did not want to use protection (even though you wanted to use protection)? Yes No If **yes**, please describe: _____

Does your partner listen to you? Yes No Does your partner respect your wishes? Yes No If **no**, please describe: _____

Have you ever had too much to drink and been sexually active even though you didn't want to? Yes No If **yes**, please describe: _____

Have you experienced a sexual activity that did not feel good, hurt you, or frighten you? Yes No If **yes**, please describe: _____

Has your partner or someone important to you emotionally or physically abused you? Yes No If **yes**, please describe: _____

Are you afraid of your partner or anyone else? Yes No If **yes**, please describe: _____



AUNT MARTHA'S HEALTH CENTER

An Introduction to Advance Directives: Living Will and Durable Power of Attorney for Health Care

What is an Advance Directive?

An Advance Directive is a document that allows you to:

- To express your wishes about your healthcare in a form that will tell others how to care for you if and when the time comes that you are unable to make or communicate decisions for yourself.
- To give an "advance directive" means:
 - To give your directions ahead of time
- Two types of advance directives:
 - The Living Will
 - The Durable Power of Attorney for Health Care

What is a Living Will?

- A written statement of your wishes regarding medical treatment if you have a terminal condition and death is imminent and you are unable to make decisions for yourself;
- If you are at the end of a terminal illness, allows you to choose the type of care you do or do not want (from among the reasonable and ethical medical care options offered by your doctor);
- Can provide instructions to your healthcare providers regarding your medical care if you are terminally ill, even if you do not wish to appoint a specific individual to serve as your agent under a Durable Power of Attorney for Health Care;
- Can be changed or revoked by you at any time;
- Is a document you are advised to share with one or more of the following persons:
 - A family member or close friend
 - Your doctor
 - Your lawyer
 - Your designated "agent" (your Durable Power of Attorney for Health Care) if you have one

Why is it a Good Idea to Have an Advance Directive?

An advance directive can help you prepare for decisions about medical care or life-threatening illness by declaring your wishes now.

If you choose not to have an advance directive, it is beneficial to discuss your wishes with persons (such as a guardian, spouse, adult children, and others close to you) who may be able make medical decisions on your behalf.

What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is:

- A written document that you can use to appoint a person of your choice (your "agent") who understands and agrees to make healthcare decisions for you;
- Becomes effective at whatever point in time that you state in your document, and as such
 - Can apply to a wide range of healthcare decisions (and is broader than a living will, which applies to terminal illness)
 - Allows you to rely on a trusted individual to decide what is best for you
- Concerns medical care decisions:
 - That you do not wish to make for yourself for whatever reason, or
 - That must be made when you are very sick and unable to communicate decisions for yourself
- Requires your agent to honor your wishes about healthcare as you have instructed
- Can be changed or revoked by you at any time

Where Can I Get More Information?

For information about different types of advance directives (Living Will, Durable Power of Attorney for Health Care, Do Not Resuscitate orders (DNR), refer to the following sources:

1. Your lawyer or legal aid service
2. Your county or state health department
3. Illinois Department of Public Health
 - Email: www.idph.state.il.us
 - Phone: 217-782-4977
 - Fax: 217-782-3987
 - Mail: 535 W. Jefferson St.
Springfield, IL 62761

AUNT MARTHA'S HEALTH CENTER CLIENT'S RIGHTS AND RESPONSIBILITIES

Aunt Martha's Health 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 our team.

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 communication 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.
- 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 otherwise 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 is needed, unless you are seeking Family Planning services and you are 12 years of age or older.
- 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 legal 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/or 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 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 extent that you are able.
- You have the responsibility to ask questions if you do not understand instructions that are given to you.
- 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 Health Center is a covered entity under HIPAA (Health Insurance Portability and Accountability Act). As a 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 daily functions (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 to 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 organization 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 information inspected is inaccurate, you have the right to request that the information be changed so that it is accurate.
- A request to inspect or amend your health information must be 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 period of time.
- If a decision is made to change the information as requested, 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 the 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 of 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 has 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 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.
- Any disclosure beyond that described above will generally require you to sign an 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 this committee, including those who are responsible for investigating complaint, are listed below:
 - Chief Executive Officer Raul Garza
 - Medical Director Jennifer Byrd
 - Complaint Recipient Ernest Gonzalez
- You may submit a complaint verbally or in writing to either the complaint recipient or to this location. If you leave a voicemail 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 website 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.