



Berrien Center, MI

Business Office
269.471.7741

Berrien Springs, MI

Administrative Office
269.471.1700

Bridgman, MI

Family / Internal
Medicine
269.465.6050

Niles, MI

Family / Internal
Medicine / Pediatrics
Walk-In Clinic
269.687.0200

Center for Women's
Health
269.687.0808

Saint Joseph, MI

Surgical Specialties
269.429.0900

Women's Specialties
269.429.8010

Stevensville, MI

Family / Internal
Medicine
269.429.9644
Pediatrics
269.429.6604
Walk-In Clinic
269.429.9677

Christian Counseling &
Psychological Services
269.429.7727

Welcome....

Thank you for choosing Southwestern Medical Clinic as your healthcare provider. We provide coordinated care with physicians and providers in Family Medicine, Internal Medicine, Pediatrics, General Surgery, Obstetrics and Gynecology, and Counseling and Psychology.

Please print and complete the attached forms for new patients and bring them with you to your first scheduled appointment. Also bring any medications you may currently be taking.

For your appointment we will also need you to bring your insurance card(s) and a government issued photo ID such as your driver's license.

Our care providers are committed to providing compassionate, quality care and welcome your questions and concerns.

Forms to complete and bring to your first appointment:

- Adult (female or male) review of systems and history forms (2 pages)
- Financial Policy (1 page)
- Be sure to review the Notice of Privacy Practices for Southwestern Medical Clinic. You'll be asked to sign a Notice Acknowledgement when you arrive for your appointment.

MALE ADULT REVIEW OF SYSTEMS Name: _____ DOB: _____

Have you recently experienced any of the following?

GENERAL

	YES	NO
Appetite Loss	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

SKIN

Change in Wart/Mole	<input type="checkbox"/>	<input type="checkbox"/>
New Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

HEENT

Headache	<input type="checkbox"/>	<input type="checkbox"/>
Visual Loss	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>
Spinning Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Sores in Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

NECK

Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Exercise Tolerance	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

BREAST

Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Blacking Out	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Black, Tarry Stool	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

MALE GENITOURINARY

	YES	NO
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Change in Bladder Habits	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Urinating at Night	<input type="checkbox"/>	<input type="checkbox"/>
Weak Stream	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL

Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

Decreased Memory	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Speaking	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Walking	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC

Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Crying	<input type="checkbox"/>	<input type="checkbox"/>
Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Planning	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE

Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGY

Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

MALE - PAST MEDICAL AND FAMILY HISTORY Name: _____ DOB: _____

Do you have or have you ever had:

HABITS	YES	NO
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you always use seatbelts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>
Number of years?	_____	
Do you smoke now?	<input type="checkbox"/>	<input type="checkbox"/>
Number of packs daily?	_____	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
How often?	_____	
Have you used drugs?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crack/Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana		
<input type="checkbox"/> Other _____		

SOCIAL	YES	NO
Do you have work or family problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lonely?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in an abusive relationship?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone ever physically hurt you?	<input type="checkbox"/>	<input type="checkbox"/>
Who helps when you are in trouble?	_____	
Do you attend religious services?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Regularly		
Member of Church / Synagogue:	_____	
Sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
One partner ever?	<input type="checkbox"/>	<input type="checkbox"/>
More than one partner, but one now?	<input type="checkbox"/>	<input type="checkbox"/>

MISCELLANEOUS	YES	NO
Have you had a positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>
Occupation: _____		
Who lives with you? _____		
<input type="checkbox"/> Single <input type="checkbox"/> Married		
<input type="checkbox"/> Long-term Relationship		
<input type="checkbox"/> Other _____		
ALLERGIES	YES	NO
Latex?	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to cleansers?	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to Betadine?	<input type="checkbox"/>	<input type="checkbox"/>
Shellfish?	<input type="checkbox"/>	<input type="checkbox"/>
X-ray dye?	<input type="checkbox"/>	<input type="checkbox"/>
Other? _____	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATIONS / MAJOR MEDICAL PROBLEMS

Date	Problem	Hospital / City	Doctor

SURGICAL HISTORY (Include surgeries from childhood)

Date	Operation Performed	Age	Complications	Hospital / City	Doctor

FAMILY HISTORY

	Living, Age	Deceased at Age	Prostate Cancer	Colon Cancer	Cancer Other _____	Stroke	Diabetes	Heart Disease	High Blood Pressure	Mental Illness	Thyroid Disease	Osteoporosis	Sickle Cell Anemia	<u>Cause of Death</u>	<u>Notes</u>
Father															
Mother															
Sibling M / F 1															
M / F 2															
M / F 3															
M / F 4															
M / F 5															
M / F 6															
Other 1															
2															

**We are committed to providing you with compassionate, quality, and accessible health care.
We are available to work with you if you have special financial needs.
The following information is provided for professional services rendered.**

Our office participates in a variety of insurance plans. **It is your responsibility to:**

- **Bring your insurance card to every visit.**
- **Obtain the necessary physician referral or pay all office fees prior to services rendered.**
NOTE: If the referral has not been obtained, you may be asked to sign an Insurance Referral Waiver.
- **Remit payment for medical care not covered under your insurance (deductible, co-pays, non-covered services, etc.) at time of service.**
- **Be prepared to pay your co-pay, deductible or non-covered services at each visit. Payment may be made by check, cash or credit card.**
- **We will not become involved in disputes between you and your insurance company regarding deductible, covered charges, co-payments, secondary insurance, “usual and customary” charges, etc., other than to supply factual information as necessary. (Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. It is your responsibility to check with your insurance plan to see what services are covered.)**
- **All private pay fees will be collected at the time of service, unless other arrangements have been made in advance.**

For patients 17 years and younger, a parent or guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors). It is the parent or guardian’s responsibility to bring the necessary referrals and insurance cards and also to make any payment due at time of service. Michigan law holds liable the adult patient requesting service to be responsible for co-payments, deductibles or non-covered charges at the time of services not a parent or spouse.

We are often asked to evaluate and /or treat a patient’s possible injury when legal action may be pending or contemplated. In such cases, the fee for the evaluation or treatment is due and payable at the time the service is rendered and not following the resolution of the legal case.

If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company’s member services department (call the number on your insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. So we can serve all our patients in a timely manner, please give us 24-hour notice if you need to cancel a scheduled appointment. Effective November 1, 2003 there will be a fee charged for any missed appointment that is not cancelled 24-hours in advance.

Any questions about financial arrangements should be directed to the Patient Accounts Department, 1-269-471-7741.

Please sign below to indicate that you have read and agree to this Financial Policy.

I understand and agree to this Financial Policy.

Patient Name

Responsible Party Signature

Date

Effective Date of this Notice: April 14, 2003

**Notice of Privacy Practices For
Southwestern Medical Clinic**

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.

OUR COMMITMENT TO YOUR PRIVACY

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 relates to your past, present or future physical or mental health or condition.

To summarize, this Notice provides you with the following important information:

- 1 How we may use and disclose your identifiable health information
- 2 Your privacy rights in your identifiable health information
- 3 Our obligation concerning the use and disclosure of your protected health information

The terms of this Notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to amend our Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a prominent location, and you may request a copy of our most current Notice during any office visit.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Southwestern Medical Clinic's Privacy Officer at (269) 471-1700

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

Our 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 our practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulation 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.

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. Additionally, we may disclose your protected health information to others who may assist in your care, such as your spouse, children, or parents.

Payment. Our practice may use and disclose your protected health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your protected health information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your protected health information to bill you directly for services and items. Also, we may disclose your protected health information to another provider involved in your care for the other provider's payment activities.

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:

- 2 Quality assessment and improvement activities
- 3 Training programs including those in which students, trainees, or practitioners in healthcare learn under supervision
- 4 Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs
- 5 Business planning activities

Appointment Reminders. We may use and disclose your protected health information to contact you and remind you of an appointment.

Treatment Options. We may use and disclose your protected health information to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. We may use and disclose your protected health information to inform you of health-related benefits or services that may be of interest to you.

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:

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

Public Health Risks. We will disclose your protected health information to public health authorities that are authorized by law to collect information for the purpose of:

- 1 **Maintaining vital records, such as births and deaths**
- 2 **Reporting child abuse or neglect**
- 3 **Preventing or controlling disease, injury or disability**
- 4 **Notifying a person regarding potential exposure to a communicable disease**
- 5 Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- 6 Reporting reactions to drugs or problems with products or devices
- 7 Notifying individuals if a product or device they may be using has been recalled
- 8 Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- 9 Notify your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care system in general.

Lawsuits and Similar Proceedings: Our practice may use and disclose your protected health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your protected health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement Purposes: We may disclose your protected health information to a law enforcement official for law enforcement purpose as follows:

- 1 As required by law for reporting of certain types of wounds or other physical injuries
- 2 Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- 3 For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- 4 Under certain limited circumstances, when you are the victim of a crime

5 To a law enforcement official if the practice has a suspicion that your death was the result of criminal conduct

6 In an emergency in order to report a crime

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.

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.

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.

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.

Inmates: Our practice may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation: Our practice may release your protected health information for workers' compensation and similar programs.

USES AND DISCLOSURES WHICH YOU AUTHORIZE

Other than as stated above, we will not disclose your protected 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.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your health information.

The right to inspect and copy your protected health information: You have the right to inspect and obtain a copy of the protected health information that may be used to make decisions about you, including patient medical records and billing records.

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 an office coordinator or the Privacy Officer, whose contact information is listed on the last page 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.

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 the Notice of Privacy Practices. Your request must state the specified restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. We 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 our Privacy Officer.

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.

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 amendment.

The right to receive an accounting of disclosures. You have the right to request an accounting of certain disclosures of your protected health information made by our practice. An "accounting of disclosures" is a list of certain disclosures our practice has made of your protected health information. 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 14, 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 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

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.

The right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your protected health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your protected health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

OUR DUTIES

Our 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 the 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. We will re-distribute our Notice if changes are made and you may ask us to give you a copy of this Notice at anytime.

COMPLAINTS

You have the right to make a complaint to our practice and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may make a complaint to our practice by contacting the Privacy Officer 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.

CONTACT PERSON

Our practice's contact person for all issues regarding patient privacy and your 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 our practice can be mailed to the Privacy Officer at:

Southwestern Medical Clinic

8008 US 31 N

Berrien Springs, MI 49103

Attn: Privacy Officer

(269) 471-1700

Notice #41403

Notice of Privacy Practices 04/13/2003