



**Faith Health Care Inc.**

Administrative Office

340 Clifty Street – Suite 1,

Somerset, KY 42501

(P) 606-425-5768 · (F) 606-425-5769

**Science Hill Community Care**

5775 N Hwy 27 – Suite 6,  
Science Hill, KY 42553

(P) 606-685-6131 · (F) 606-685-6179  
(F) 855-359-2404

**Community Care Clinic**

126 Franklin Drive,  
Monticello, KY 42633

(P) 606-396-3534 · (F) 606-396-3535  
(F) 606-396-3536

**Nancy Family Care**

9919 West Hwy 80,  
Nancy, KY 42544

(P) 606-288-0019 · (F) 606-288-0020  
(F) 855-618-2148

**Mount Vernon Community Care**

325 Richmond Street,  
Mount Vernon, KY 40456

(P) 606-331-5720 · (F) 606-208-9348

**LC Rheumatology Somerset**

26 Oxford Way – Suite A,  
Somerset, KY 42503

(P) 606-802-2300 · (F) 866-538-6128

**LC Rheumatology London**

1675 S Main Street – Suite 4,  
London, KY 40741

(P) 606-266-8266 · (F) 606-266-8300

**Patient Information**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell/Alternate \_\_\_\_\_

Email address \_\_\_\_\_

Pharmacy Name/Location \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Income: Self \_\_\_\_\_ Weekly/Bi-weekly/ Annually Hourly rate \_\_\_\_\_ Hours worked per week \_\_\_\_\_

Spouse \_\_\_\_\_ Weekly/Bi-weekly/ Annually Hourly rate \_\_\_\_\_ Hours worked per week \_\_\_\_\_

Household size \_\_\_\_\_

Father \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Employer \_\_\_\_\_

Mother \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Employer \_\_\_\_\_

Are you a Veteran?  Yes  No    Do you smoke?  Yes  No    Are you disabled?  Yes  No

Living Situation:  Own  Rent  Motel/Hotel  Car/Vehicle  Halfway House/Shelter  Homeless Shelter  
 Permanent Supportive Housing  Street  Transitional  Other \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced  Domestic Partner

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Gender:  Male  Female  Transgender Male  Transgender Female  Other  Do not wish to disclose

Pronouns:  he/him/his/his/himself  she/her/her/hers/herself  they/them/their/theirs/themselves

Another Pronoun, please specify:

Sexual Orientation:  Straight  Lesbian/Gay  Bisexual  Other  Unsure  Do not wish to disclose

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

**Employment Status:**  Employed  Unemployed  Retired  Self-Employed  Student

**Migrant Worker?**  Yes  No

**Education Level Completed:**  Less than High School Graduate  High School Graduate  
 Some College/Associate's Degree  Bachelor's Degree or higher

**What language should your information be provided in?** \_\_\_\_\_

**How well do you understand English?**  Very Well  Moderate  Very Little  None

**Advanced Directives:**  Yes (please provide a copy)  No

**Insurance Information**

**Is this a Workman's Compensation or auto insurance claim? (If so, please provide this information)**  Yes  No

**Do you have Medicaid?**  Yes  No **Have you applied?**  Yes  No **Policy Number?** \_\_\_\_\_

**Do you have health insurance?**  Yes  No

Name of Insurance \_\_\_\_\_

Person Carrying Insurance \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

I understand that my medical information is confidential. I authorize the exchange of information between Faith Healthcare and any other providers or organizations only as necessary for treatment, payment, or healthcare operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available upon request.

*I hereby acknowledge the above statements and authorize treatment by Faith Healthcare.* Initials \_\_\_\_\_

I authorize Faith Healthcare to release my medical records to my insurance carrier, worker's compensation carrier, and/or my attorney. I hereby assign all medical benefits, to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plan, to Faith Healthcare. This assignment and authorization will remain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all medical charges associated with my treatment, whether they are paid by an insurance company or not.

Patient Signature or guardian (if minor) \_\_\_\_\_ Date \_\_\_\_\_

Name and relationship (if not patient) \_\_\_\_\_ Date \_\_\_\_\_

**Health and Psychiatric History**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Are you here for a routine exam?  Yes  No

**MEDICAL HISTORY** – Please check if you have had any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Swollen Legs/Ankles          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Hallucinations __ visual __ auditory   |
| <input type="checkbox"/> Eye Problems        | <input type="checkbox"/> Varicose Veins               | <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Attention Deficit Hyperactive Disorder |
| <input type="checkbox"/> Severe Headaches    | <input type="checkbox"/> Blood Clots                  | <input type="checkbox"/> Serious Injury/MVA   | <input type="checkbox"/> Schizophrenia                          |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Bleeding Problems            | <input type="checkbox"/> eating disorder      | <input type="checkbox"/> Mood Disorders                         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems             | <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Oppositional Defiant Disorder (ODD)    |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Bowel Problems               | <input type="checkbox"/> Severe Depression    | <input type="checkbox"/> Major Depressive Disorder (MDD)        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Bipolar Disorder     | <b>yes / no Previous suicidal attempts</b>                      |
| <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Liver Problems               | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD)  |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Gallbladder Problems         | <u>WOMEN</u>                                  |   |
| <input type="checkbox"/> Seizure             | <input type="checkbox"/> Urinary Tract Infections     | Date of last menstrual period                 |   |
| <input type="checkbox"/> Thyroid Problem     | <input type="checkbox"/> Sexually Transmitted Disease | ____/____/____                                |   |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Pelvic Infections            | # of Pregnancies _____                        |   |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Arthritis                    | # of Births _____                             |   |

<p><b>Please describe/explain any of the above problems</b></p>   	<p><b>List any PSYCHIATRIC CARE, HOSPITALIZATIONS or SURGERIES you have had. Please list the facility and the year.</b></p>   
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Are you disabled? YES / NO If yes please list the reason(s) why.

Do you have any legal issues? \_\_\_\_\_

**FAMILY HISTORY (Father, Mother, Brother, Sister, Grandmother, Grandfather)**

	Relationship		Relationship
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Breast Cancer	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Colon Cancer	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Ovarian Cancer	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Other Cancer	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Chronic Lung Disease	_____	<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Bleeding Problems	_____	<input type="checkbox"/> Drug/Alcohol Problems	_____

**FAMILY HEALTH** – List the present age/health status of the following family members. If deceased, then list age and cause of death.

FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLINGS \_\_\_\_\_

**SOCIAL HISTORY and PSYCHOSOCIAL HISTORY**

**Habits**

- Smoking** If yes, how many packs a day? \_\_\_\_\_ How many years? \_\_\_\_\_
- Smokeless Tobacco use** If yes, what type? \_\_\_\_\_ How many years? \_\_\_\_\_
- Alcohol** If yes, how many drinks a day? \_\_\_\_\_ Drinks per week? \_\_\_\_\_
- Street drug use** If yes please circle what type. **Opiates, Alcohol, Methamphetamine, Cocaine, Heroin, Kratom, Delta 8/CBD, Fentanyl, other**
  
- Caffeine oz per day** \_\_\_\_\_
- Seat belt use**
- Regular exercise**

**Personal Profile**

- Marital Status  Married  Single  Divorced  Widowed
- Number of living children \_\_\_\_\_ How many live with you and who are they \_\_\_\_\_
- School completed:  High School  College  Graduate Degree
- Current/Most recent job: \_\_\_\_\_

**Other**

- Are you or have you been **sexually/physically** mistreated? \_\_\_\_\_
- Do you want to talk to someone about this? \_\_\_\_\_

**Review of Symptoms – Check all symptoms that you are currently experiencing**

**Constitutional**

- Fever
- Chills
- Sweats/Night Sweats
- Fainting
- Weight Change
- Fatigue
- Seizures
- Dizziness
- Sleeping difficulties

**Eyes**

- Change in Vision
- Burning/itching eyes
- Blurred/double vision
- Redness/Eye pain

**Ears, Nose, Mouth, Throat**

- Ear pain
- Ringing in ears
- Dry mouth
- Colds
- Sore throat
- Hoarseness
- Difficult swallowing

**Respiratory**

- Shortness of breath
- Chronic cough
- Bloody sputum
- Wheezing

**Cardiovascular**

- Chest Pain
- Palpitations/heart fluttering

**Gastrointestinal**

- Abdominal Pain
- Heartburn, indigestion
- Nausea/Vomiting
- Change in Appetite
- Change in bowel habits
- Constipation of diarrhea
- Dark/Bloody stools
- Rectal bleeding

**Urinary**

- Painful urination
- Frequent urination
- Urinary urgency/incontinence
- Blood in urine
- Getting up at night to urinate

**Musculoskeletal**

- Backache, back pain
- Weakness
- Joint pain/stiffness
- Muscle cramps
- Swelling of hands, feet, ankles
- Leg pain, redness

**Skin**

- Change in moles, freckles

**Hematologic/Lymphatic**

- Swollen lymph glands
- Easy bruising
- Easy bleeding

**Endocrine**

- Excessive thirst/urination
- Cold/Heat intolerance

**Breast**

- Breast Lumps
- Breast Pain
- Breast Nipple Discharge

**Neurological/Emotional**

- Memory Change
- Numbness/tingling
- Depression
- Anxiety
- Mood swings

**Women**

- Bleeding/pain with intercourse
- Vaginal discharge/odor
- Pelvic pain
- Vulvar/vaginal itching/burning
- Excessive menstrual bleeding
- Menstrual cramps
- Problems with sexual function

**Men**

- Pain/lump in testicles

\_\_\_ Rash  
\_\_\_ Change in hair growth, loss  
\_\_\_ Nodule

\_\_\_ Difficulty with erections  
\_\_\_ Problems with sexual function



## Faith Healthcare, Inc.

### GENERAL CONSENT FOR CARE AND TREATMENT

**TO THE PATIENT: YOU HAVE THE RIGHT, AS A PATIENT, TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO ANY SUGGESTED TREATMENT OR PROCEDURE AFTER PLAN HAS BEEN RECOMMENDED. THIS CONSENT FORM IS SIMPLY AN EFFORT TO OBTAIN YOUR PERMISSION TO PERFORM THE EVALUATION NECESSARY TO IDENTIFY APPROPRIATE TREATMENT AND/OR PROCEDURE FOR ANY IDENTIFIED CONDITIONS(S).**

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating:

- This consent in continuing in nature even after a specific diagnosis has been made and treatment recommended
- You consent to treatment at this office or any other satellite office under common ownership
- This consent will remain fully effective until it is revoked in writing
- You have the right at any time to discontinue services

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider. We encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Date



**Faith Healthcare, Inc.**

**Telehealth Consent Form**

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

- This form is for your consent for participation in telehealth sessions, visits, etc. with your provider as needed.
- All existing laws and regulations regarding your access to treatment information apply during all telehealth visits. The visit will not be recorded or stored for any purpose. Appropriate and reasonable efforts have been made to eliminate confidentiality and/or privacy risks associated with the modality of telehealth. All existing confidentiality protections under federal law apply to information disclosed during a telehealth visit.
- The system that will be used during telehealth visits is compliant with HIPAA, however it is your responsibility as the patient to be in a confidential and secure environment (both digitally and physically) to ensure that your health information is protected.
- Patients who participate in telehealth visits are prohibited from recording, taking screenshots, or allowing non-approved individuals to participate in the telehealth visit. Your provider has the right to discontinue or refuse telehealth visits if they feel the surrounding environment is not appropriate or private enough for the patient or provider.
- During your telehealth visit, the provider will introduce themselves and anyone else present in the provider's room at the time.
- There are limitations with telehealth visits, such as being unable to conduct physical examinations, which may limit your provider's ability to diagnose and treat certain conditions. Telehealth visits may require follow-up visits in person based on the diagnosis made. Not all visit types will be acceptable, nor desirable, to be performed via telehealth.
- Potential risks associated with telehealth visits include interruption of the audio/video link or disconnection from the internet on either the patient's or provider's end.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## Faith Healthcare, Inc.

### Controlled Medication Agreement

This contract is binding between myself and my primary care provider at Faith Healthcare, Inc. regarding this policy for being prescribed any controlled substance(s) for the treatment of pain, anxiety, seizures, obesity, or other diagnosis of medical conditions that necessitate said substance(s).

I understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.
- I will participate in all other types of treatment I am asked to do.
- I will keep the medication safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it without first talking to my prescriber/primary care provider.
- I will not call between appointments, at night, or at the weekends to request a refill. I understand that prescriptions will be filled only during scheduled office visits with the treatment team of Faith Healthcare.
- I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the office staff immediately.
- I will treat the office staff respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.
- I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.
- I will sign a release form to let the prescriber/primary care provider speak to all other doctors or providers that I see.
- I will inform the staff and primary care provider at Faith Healthcare of all other medications that I take and make it known right away if I have a prescription for a new medication.
- I will only use one pharmacy to get my medication(s).
- I will not get any opioid pain medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium, etc.) or stimulants (Ritalin, amphetamines, etc.) without telling a member of the treatment team at Faith Healthcare before I fill that prescription. I understand that the only exception to this is if I need pain medication for an emergency at night or on the weekends.
- I will not use illegal drugs including, but not limited to, heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.
- I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that this will occur at a minimum of once a month, if I am prescribed any controlled substance while under the care of Faith Healthcare. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.
- I will keep up to date with any bills from the office and tell a member of the treatment team immediately if I lose my insurance or cannot pay for treatment anymore.
- I agree to consult with any pain clinic physicians or psychiatrists if so, requested by the treatment team of Faith Healthcare.
- I agree to have KASPER reviewed and discussed at any time deemed necessary by my primary care provider at Faith Healthcare for medication care/treatment and continuation of care.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



**Faith Healthcare, Inc.**

**AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize the USE & DISCLOSURE of all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information of HIV/AIDS information) of:

Patient Name (Print) \_\_\_\_\_ Phone \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Please list any physicians or organizations authorized to release the information and any contact information:

\_\_\_\_\_  
\_\_\_\_\_

For the following dates of treatment (include specific description of information requested): \_\_\_\_\_ ALL RECORDS

For the purpose of:

- \_\_\_\_\_ Further Medical Care
- \_\_\_\_\_ Legal Reasons
- \_\_\_\_\_ Self
- \_\_\_\_\_ Other (please specify)

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment, or healthcare operations. I may inspect or copy any information used/disclosed under this authorization.

This authorization and request are fully understood and are made voluntarily on my part. I release the above-named facility of Faith Healthcare of any legal liability that may arise from the release of the information requested.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has been taken. This authorization will automatically expire one year from the date on which it is signed. Cancellation of this authorization before expiration must be made in writing and sent to the Health Information Management.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian/Legal Rep. Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_





## Faith Healthcare, Inc.

### NO SHOW POLICY

Thank you for trusting your medical care to Faith Healthcare. When you schedule an appointment with Faith Healthcare, we set aside enough time to provide you with the highest quality care. If you need to cancel or reschedule an appointment, contact our office as soon as possible, and no later than 24 hours before your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- If you have three (3) No Show or cancellation/reschedule with no 24-hour notice, your provider reserves the right to decline future appointments and care.
- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager to discuss future appointments. Should you need to cancel/reschedule after regular business hours Monday through Friday, or on a weekend, you may leave a message. Messages left are acceptable.

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Patient Signature

---

Date

## HIPAA NOTICE OF PRIVACY PRACTICES

**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 IN ITS ENTIRETY.**

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. PHI is information about you, including demographic information that may identify you and relates to your past, present, or future physical or mental health condition(s) and related health care services.

### **Uses and Disclosures of Protected Health Information (PHI)**

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your PHI 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 example, we would disclose your protected health information to a home health agency that provides care for you or to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.

**Payment:** Your PHI will be used to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan.

**Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, licensing, and conducting or arranging other business activities. We may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready for your visit. We may use or disclose your PHI to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable disease(s), health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers' compensation, or inmate required uses & disclosures.

Under the law, we must make disclosures to you when required by the Department of Health & Human Services to determine our compliance with Section 164.500.

**Other Permitted and Required Uses and Disclosures:** Will be made only with your consent, authorization, or opportunity to object unless required by law. **You may revoke this authorization** at any time, in writing, except to the extent that your provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

Following is a statement of your rights with respect to your protected health information,

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to anyone who may be involved in your care or for the notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another healthcare professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice electronically.

**You may have the right to have your provider amend your protected health information.** 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.

**You have the right to receive an accounting of certain disclosures we have made of your protected health information.**

**You have the right to use any pharmacy of your choice for medications prescribed by Faith Healthcare.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. Our HIPAA Compliance Officer can be contacted at **(606) 425-5768**. **We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on **November 1, 2019**.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at **(606) 425-5768**.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please list the person(s) that are granted access to your medical records.**

<b>Name</b>	<b>Phone</b>	<b>Relationship</b>
_____	_____	_____
_____	_____	_____