

REGISTRATION FORM

(Please Print)

Today's date: ____/____/____

PATIENT INFORMATION

Last name: _____ First: _____ Middle: _____ Mr. Miss Gender: M F

Is this your legal name? Yes No Married Divorced Mrs. Ms. Birth date: ____/____/____
 Single Widowed

Primary address: _____ Social Security no.: _____

City: _____ State: _____ ZIP Code: _____ Home / Cell () _____ Work:() _____

Spouse/Parent Name: _____ Spouse/Parent phone: () _____ Spouse/Parent DOB: ____/____/____

Email: _____ Pharmacy Name/Address: _____

Indicate race: American Indian Black Asian White Multiracial Not Provided Other _____

Indicate Ethnicity: Hispanic Non-Hispanic

Primary Language: English Spanish Chinese French Arabic Vietnamese Other _____

Referred to clinic by (please check one box):

Dr. Insurance Plan Hospital Family Friend Close to home/work Internet Other _____

Referring Physician: (First) _____ (Last) _____ Primary Care Physician: _____

IN CASE OF EMERGENCY

Name of local friend or relative: _____ Cell: () _____

Relationship to patient: _____ Work: () _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Address (if different): _____

Birth date: ____/____/____ Phone #: () _____

Is this person a patient here? Yes No Is this patient covered by insurance? Yes No

BCBS UHC AETNA CIGNA HUMANA TRICARE Other _____

Policy Holder name: _____ Policy Holder S.S. #: _____ Birth date: ____/____/____

Patient's relationship to policy holder: Self Spouse Child Other _____

Name of secondary insurance: _____ Secondary policy holder name: _____ Birth Date: _____

Patient's relationship to policy holder: Self Spouse Child Other _____

I authorize the physician(s) of Lakeside Allergy ENT to treat me. I authorize any physician/agent of Lakeside Allergy ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of Lakeside Allergy ENT. I authorize any physician/agent of Lakeside Allergy ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay the medical benefits directly to the physician(s) of Lakeside Allergy ENT. I understand that I am financially responsible for any balance. I agree that a photocopy of this agreement will be considered the same as the original.

Patient/Guardian signature _____ Date _____

Lakeside Allergy, Ear, Nose, & Throat

Gregory A. Young, M.D., PA

Jeffrey A. West, M.D FACS

Kenny Iloabachie, M.D.

FINANCIAL POLICY

Co-Pays, Coinsurance, and Deductibles are due at the time of service. We accept **Cash, VISA, MasterCard, Discover, and American Express.**

REFERRALS: If you have an HMO, or similar plan, you will need a referral from your primary care physician to see our specialists. If we have not received this referral prior to your arrival at our office, your appointment may need to be rescheduled. It is YOUR responsibility to know if a referral is required and to obtain one.

INSURANCE BENEFITS: Please be aware that when a patient requires a visit to a specialist, there are procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as procedures/surgeries. An estimated cost of the procedure will be given before the procedure is performed, and must be paid in full at time of service. The possible procedures which often are performed in this practice during your visit include, but are not limited to:

- Nasal Hemorrhage Control
- Nasal Endoscopy with/without Debridement- This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using a standard nasal speculum to possibly remove crusting or tissue.
- Flexible Laryngoscopy- This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.
- Cerumen (ear wax) removal
- Foreign Body Removal
- Tympanostomy/Myringotomy
- Audio-Comprehensive
- Otoacoustic Emissions
- Binocular Microscopy

FORM FEES: Any forms (i.e. FMLA, Short-term disability, other extended leave of absences, etc.) which require our physicians to complete, must be given to our office staff in a timely manner and will require a \$35.00 fee before being completed. Please allow up to 10 business days for completion.

MEDICAL/BILLING RECORDS FEE: Any request for medical or billing records must be accompanied by an authorization for release of information (obtainable from the front desk). We will make every effort to provide your records via copies or electronically, within 10 business days, so please make your request well in advance of other physician appointments. There are fees for the release of records.

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RETURNED CHECK FEE: There is a \$35.00 fee for checks returned for any reason. Lakeside Allergy ENT does report all bad check to the Justice of the Peace.

COLLECTION AGENCY: Please be aware that Lakeside Allergy ENT reports unpaid bills to a collection agency. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance of your account. Any patient sent to collection forfeits any future appointments unless the balance is paid in full.

SURGERY PAYMENTS: If surgery is recommended, you may be required to pay a portion of your deductible and/or coinsurance prior to the date of surgery. Any quote received for surgery will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim.

ASSIGNMENT OF BENEFITS: I request that payment of insurance benefits, be made on my behalf to Lakeside Allergy, Ear, Nose, & Throat or Gregory A. Young, M.D. PA or Jeffrey A. West, M.D. FACS, or Kenny Iloabachie, M.D., for any services provided to me. I authorize the release of any medical or other information necessary to determine these benefits or benefits payable by my insurance carrier. A copy of this authorization will be sent to my insurance carrier if requested. The original authorization will be kept on file at Lakeside Allergy, Ear, Nose, & Throat.

FINANCIAL RESPONSIBILITY: I have read this notice of possible procedures necessary to verify or obtain a diagnosis and evaluate for treatment. I am aware that these procedures will be billed to my insurance, if any. I understand there are other procedures which may be performed as part of my diagnosis or treatment that may not be listed above. I will be responsible for any amount not covered by my insurance policy. If I do not have insurance, I am aware that I will be responsible for the bill. It is my responsibility to notify Lakeside Allergy ENT of any changes in my insurance coverage. I understand by signing this form I am accepting full financial responsibility as explained above for all payment for services rendered.

DISCLOSURE STATEMENT: Please be advised that the physicians may have a direct financial interest in a facility to which our practices refers. You have a right to choose the facility of your choice.

(Patient/Guardian Signature)

(Date)

Lakeside Allergy, Ear, Nose, & Throat

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CONSENT FOR TREATMENT

I HEREBY AUTHORIZE EVALUATION AND TREATMENT BY DR.'S YOUNG, WEST, AND/OR ILOABACHIE.

(Patient/Guardian Signature)

(Date)

By signing this document, I also acknowledge that I have received a copy of Lakeside Allergy, Ear, Nose, & Throat's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of the privacy rights.

Signature: _____

Printed Name: _____

Relationship to patient, if different: _____

Witness: _____

Date: _____

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ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify if applicable) of my information:

Patient Name: _____

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____

Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____

Date: _____

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AUTHORIZATION FOR DISCLOSURE FOR PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient's Name: _____

Patient's Date of Birth: _____

Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:

Lakeside Allergy, Ear, Nose & Throat
1005 W. Ralph Hall Pkwy., Ste. 107
Rockwall, TX 75032

B. Person(s) or Organization(s) authorized to receive the information:

C. Specific description of the information that may be used or disclosed (including date(s)).

D. Specific description of how the information will be used:

- 1) I understand that this authorization will **expire** on ____/____/____
- 2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization at any time by notifying Lakeside Allergy, Ear, Nose & throat in writing.
- 3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
- 4) I may **inspect or copy** any information used or disclosed under this agreement.
- 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

E. Authorization to leave messages:

I give permission for the staff of Lakeside to give or leave messages or information regarding medication, surgery, lab results, appointments and healthcare by the following:

- | | |
|--|--|
| <input type="checkbox"/> Home telephone answering machine
(____)_____-_____ | <input type="checkbox"/> My Email Address
_____ |
| <input type="checkbox"/> Cell Phone Voicemail
(____)_____-_____ | <input type="checkbox"/> USPS Mailing Address
_____ |

Please indicate any additional names of individuals with whom we may speak with concerning your care:

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

NOTE:

- You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.")
- You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).
- You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, PhD/Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Consent for Use/Disclosure of Health Information / This form does not constitute legal advice and covers only federal, not state laws.

Lakeside Allergy, Ear, Nose, & Throat

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***** IMPORTANT INFORMATION – PLEASE READ *****

IN OFFICE PROCEDURE AND TESTING CONSENT FINANCIAL ACKNOWLEDGEMENT

Lakeside Allergy wants to inform you of certain additional charges that may apply to your visits if you are complaining of sinus, ear or throat problems.

If you are here for a consultation, new patient visit, follow-up visit, or post-op visit, it may be necessary for the doctor to do certain procedures such as nasal endoscopy, laryngoscopy, microscopy, hearing tests, or allergy screens. Insurance companies sometimes apply these procedures/surgeries to your coinsurance and/or deductible as they are classified as “in office procedures/surgery”.

You may owe more than your office visit co-payment at check out. If you have any questions about your specific insurance plan benefit and your financial responsibility, please ask one of the receptionists or check with your insurance carrier before seeing the doctor. Please indicate your understanding and consent of these procedures by signing below.

I acknowledge and understand that additional testing including procedures may be performed for my evaluation and treatment if the doctor finds it medically necessary. I also understand that I may owe more money than my office visit or copay should the procedure be applied to my deductible and/or coinsurance.

Patient Name

Date

Signature of Patient or Guardian

Relationship

Witness

Date

Lakeside Allergy, Ear, Nose, & Throat

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Jeffrey A. West, M.D FACS

Kenny Iloabachie, M.D.

DATE: ____ / ____ / ____

NAME: _____ DATE OF BIRTH: ____ / ____ / ____ AGE: _____

WEIGHT: _____ HEIGHT: _____ B/P: _____

REASON FOR VISIT: _____

When symptom first occurred: _____

Possible Cause: _____

Has this problem occurred in the past? Yes No

MEDICAL HISTORY

Please list all medical problems that you currently have and when they first occurred:

<u>Medical Problem</u>	<u>Date First Occurred</u>
<input type="checkbox"/> Asthma	____ / ____ / ____
<input type="checkbox"/> Diabetes	____ / ____ / ____
<input type="checkbox"/> Heart Disease	____ / ____ / ____
<input type="checkbox"/> Cancer	____ / ____ / ____
<input type="checkbox"/> Stomach Ulcer	____ / ____ / ____
<input type="checkbox"/> Free Bleeding	____ / ____ / ____
<input type="checkbox"/> Easy Bruising	____ / ____ / ____
<input type="checkbox"/> _____	____ / ____ / ____
<input type="checkbox"/> _____	____ / ____ / ____
<input type="checkbox"/> _____	____ / ____ / ____

SURGICAL HISTORY

Please list any previous surgeries and when they were performed. Also list any problems with anesthesia.

1. _____ Date: ____ / ____ / ____
2. _____ Date: ____ / ____ / ____
3. _____ Date: ____ / ____ / ____
4. _____ Date: ____ / ____ / ____

Problems with anesthesia: _____

Lakeside Allergy, Ear, Nose, & Throat

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NAME: _____

DATE OF BIRTH: ____/____/____ AGE: _____

FAMILY HISTORY

Please **Check** all of the following conditions that run in your family:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Retinitis Pigmentosa |
| <input type="checkbox"/> Anesthetic Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Angioedema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |

SOCIAL HISTORY

- Cigarettes: Yes No Packs/day: _____ Years: _____ I quit _____ years ago
Other Tobacco: Yes No Cigar Dip/Chew
Alcohol: Yes No Drinks/day: _____ Years: _____

MEDICATION HISTORY

List the medications and supplements that you currently take. Include prescription medication, over the counter medications, supplements, and herbal medicines, dosage, and strength.

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____
6. _____ Dosage: _____
7. _____ Dosage: _____
8. _____ Dosage: _____

DRUG ALLERGIES

List any drug allergies that you have experienced and the type of reaction that occurred. _____

FOOD AND ENVIRONMENTAL ALLERGIES

List any environmental or food allergies that you have experienced and the type of reaction that occurred. _____

Lakeside Allergy, Ear, Nose, & Throat

DATE: ____ / ____ / ____

NAME: _____ DATE OF BIRTH: ____ / ____ / ____ AGE: _____

Please indicate what symptoms you are currently experiencing:

FEVER	<input type="checkbox"/> Yes <input type="checkbox"/> No	DYSPHAGIA (PROBLEM SWALLOWING)	<input type="checkbox"/> Yes <input type="checkbox"/> No
NIGHT SWEATS	<input type="checkbox"/> Yes <input type="checkbox"/> No	HEPATITIS	<input type="checkbox"/> Yes <input type="checkbox"/> No
WEIGHT LOSS	<input type="checkbox"/> Yes <input type="checkbox"/> No	GERD (HEARTBURN)	<input type="checkbox"/> Yes <input type="checkbox"/> No
BLINDNESS	<input type="checkbox"/> Yes <input type="checkbox"/> No	PREGNANCY	<input type="checkbox"/> Yes <input type="checkbox"/> No
VISION CHANGE	<input type="checkbox"/> Yes <input type="checkbox"/> No	URINARY RETENTION (Problem Urinating)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ITCHING EYES	<input type="checkbox"/> Yes <input type="checkbox"/> No	RASH	<input type="checkbox"/> Yes <input type="checkbox"/> No
NASAL ALLERGY	<input type="checkbox"/> Yes <input type="checkbox"/> No	MOLE CHANGE	<input type="checkbox"/> Yes <input type="checkbox"/> No
NASAL OBSTRUCTION	<input type="checkbox"/> Yes <input type="checkbox"/> No	SKIN CANCER	<input type="checkbox"/> Yes <input type="checkbox"/> No
FACIAL PAIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	SYNCOPE (BLACKING OUT)	<input type="checkbox"/> Yes <input type="checkbox"/> No
SINUSITIS	<input type="checkbox"/> Yes <input type="checkbox"/> No	SEIZURE	<input type="checkbox"/> Yes <input type="checkbox"/> No
SNORING	<input type="checkbox"/> Yes <input type="checkbox"/> No	WEAKNESS	<input type="checkbox"/> Yes <input type="checkbox"/> No
SLEEP DISORDER (Breathing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	SPEECH DIFFICULTY	<input type="checkbox"/> Yes <input type="checkbox"/> No
LUMP IN THROAT	<input type="checkbox"/> Yes <input type="checkbox"/> No	HEADACHES	<input type="checkbox"/> Yes <input type="checkbox"/> No
VOICE CHANGE	<input type="checkbox"/> Yes <input type="checkbox"/> No	PARESTHESIA (NUMBNESS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEARING LOSS	<input type="checkbox"/> Yes <input type="checkbox"/> No	DRUG ABUSE	<input type="checkbox"/> Yes <input type="checkbox"/> No
OTALGIA (EAR PAIN)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ALCOHOL ABUSE	<input type="checkbox"/> Yes <input type="checkbox"/> No
TINNITUS (RINGING IN THE EARS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ANXIETY	<input type="checkbox"/> Yes <input type="checkbox"/> No
NECK MASS	<input type="checkbox"/> Yes <input type="checkbox"/> No	DEPRESSION	<input type="checkbox"/> Yes <input type="checkbox"/> No
VERTIGO (DIZZINESS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	DIABETES (INSULIN)	<input type="checkbox"/> Yes <input type="checkbox"/> No
SORE THROAT	<input type="checkbox"/> Yes <input type="checkbox"/> No	DIABETES II (ORAL MEDICATION)	<input type="checkbox"/> Yes <input type="checkbox"/> No
CHEST PAIN/PRESSURE	<input type="checkbox"/> Yes <input type="checkbox"/> No	GOITER	<input type="checkbox"/> Yes <input type="checkbox"/> No
EXERCISE INTOLERANCE	<input type="checkbox"/> Yes <input type="checkbox"/> No	THYROID NODULE	<input type="checkbox"/> Yes <input type="checkbox"/> No
ASTHMA	<input type="checkbox"/> Yes <input type="checkbox"/> No	HYPERTHYROIDISM (THYROID TOO HIGH)	<input type="checkbox"/> Yes <input type="checkbox"/> No
COUGH	<input type="checkbox"/> Yes <input type="checkbox"/> No	HYPOTHYROIDISM (THYROID TOO LOW)	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEMOPTYSIS (COUGHING BLOOD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	HYPERCALCEMIA (CALCIUM TOO HIGH)	<input type="checkbox"/> Yes <input type="checkbox"/> No
DYSPNEA(SHORTNESS OF BREATH)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ABNORMAL BLEEDING OR BRUISING	<input type="checkbox"/> Yes <input type="checkbox"/> No
TUBERCULOSIS	<input type="checkbox"/> Yes <input type="checkbox"/> No	LYMPH NODE ENLARGED	<input type="checkbox"/> Yes <input type="checkbox"/> No
NAUSEA	<input type="checkbox"/> Yes <input type="checkbox"/> No	SKIN RASH	<input type="checkbox"/> Yes <input type="checkbox"/> No
VOMITING	<input type="checkbox"/> Yes <input type="checkbox"/> No	FOOD ALLERGIES	<input type="checkbox"/> Yes <input type="checkbox"/> No

LAKESIDE ALLERGY, EAR, NOSE & THROAT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws requires us to maintain the privacy of your health information and to inform you about our privacy practices as described below. This Notice will remain in effect until it is amended or replaced.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes to our privacy practices and the new forms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes.

Treatment: We may use your health information to provide you with our professional services. We have established minimum "necessary or need to know" standards that limit various staff members access to your health information according to their primary job functions.

Disclosure: We may disclose and/or share your health care information with other health care professionals who provide treatment and service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and / or person you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to see payment for services we provide to you. This disclosure involves our business office and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and / or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar duties.

Required by Law: We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use or disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of the law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medication, product recalls, disease/infection exposure and to prevent and control disease, injury, and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: It is our policy to provide you with appointment reminders, including but not limited to voicemail messages, postcard, or letters.

LAKESIDE ALLERGY, EAR, NOSE & THROAT

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form which is available from the office. You may also request access by sending us a letter to the address at the bottom of this Notice. Copies, if requested will be \$25.00

Amendment: You have the right to amend your healthcare information. If you feel it is inaccurate or incomplete, your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we can make of your health care information (when we make a routine disclosure of your to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures, therefore these are not available). You have the right to a list of instances in which we, or our business associates disclosed information for reasons other than payment, payment or healthcare operations. You can request non-routine disclosures going back 6 years.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, will abide by our agreement (except in emergencies).

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to the Lakeside office manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can file a complaint in writing or request a Complaint Form. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

HOW TO CONTACT LAKESIDE:

Practice Name: Lakeside Allergy, Ear, Nose & Throat

Phone: 972-771-5443 **Fax:** 972-771-5444

Address: 1005 W. Ralph Hall Pkwy, Suite 107, Rockwall, Tx 75032