Metro Atlanta Urology
and
Pelvic Health Center

GENERAL
New Patient Demographics

Do you need assistance with these forms? ☐ Y ☐ N

DEMOGRAPHICS

Last Name: First: MI:	DOB: (MM/DD/YYYY) Gender: ☐ Male ☐ Female ☐ Other
Address:	Social Security No.:
City: State: Zip:	Phone:
Primary Care Physician: (Name)	(Phone)
Referring Physician: (Name)	(Phone)
Emergency Contact: (Name) (Phone)	(Relationship)

Additional Information

Email: Race:	Ethnicity:
Preferred Pharmacy:	Preferred Language: ☐ English ☐ Spanish ☐ Other
Pharmacy Address:	(Phone)
Do you have an Advance Directive (Living Will)? ☐ Y ☐ N	

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have been provided a copy of Metro Atlanta Urology and Pelvic Health Center's Privacy Practices as required by the Health Insurance Portability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I authorize Metro Atlanta Urology and Pelvic Health Center to release my health information topersons/organizations listed below:

☐ Same as Emergency Contact	Other person/organization Name:____________________
	Relationship:____________ Phone: ____________

By signing this document, I acknowledge the following:

- I have been provided a copy of Metro Atlanta Urology and Pelvic Health Center's Privacy Practices
- I have reviewed this authorization to release my medical records and confirm it is correct.
- I understand that this authorization will remain in effect for a period of one (1) year, unless revoked.
- I may revoke this authorization at any time by writing to: Metro Atlanta Urology and Pelvic HealthCenter, ATTN: Medical Records
- 1301 Shiloh Rd NW, Suite 660, Kennesaw, GA 30144: The revocation will become effective upon receipt of the notice.

________________________ ______________
Signature of Patient (or guardian) Date

OFFICE

For Office Use Only

Staff Initials:	☐ Patient Photograph	**Scan ALL patient documents**		
		☐ Pt. ID	☐ Insurance Card	
		☐ Pt. Demographics	☐ Pt. History	☐ Pt. Surveys

Metro Atlanta Urology and Pelvic Health Center

Annual – Financial Policy & Consents

Please *initial and sign* to your acknowledgement and consent for Medical Treatment and Payment Policy.

PAYMENT POLICY

Thank you for choosing Metro Atlanta Urology and Pelvic Health Center as your provider. We are committed to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

- ***Insurance.*** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you mayhave regarding your coverage.
- ***Booking Fee.*** Surgeries, In-office procedures and in-office diagnostic tests require a scheduling fee of $75 to secure the appointment. At the time of booking, the booking fee amount and payment instructions will be provided to you. Payments can be made either through a payment link sent or in person at the clinic. Appointment is not confirmed until payment of scheduling fee is completed. Scheduling fees are refundable against treatment but non-refundable nor transferable if an appointment is cancelled or re-arranged less than 2 working days before it was scheduled.
- ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time ofservice. This arrangement is part of your contract with your insurance company. If your account isturned over to a collection agency, a $100 collections processing fee will be added to any outstanding balance.
- ***"No-show" or late cancellation.*** If you do not cancel or reschedule your appointment with at least 2 business days notice, we will assess a $75 "no-show" service charge to your account. This fee will be waived the first time to account for emergencies.
- ***Non-covered services***. Please be aware that some of the services you receive may be non- covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- ***Proof of insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proofof insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- ***Claims submission***. We will submit your claims and assist you in any way we can to help get yourclaims paid. Please be aware that any unpaid balances are your responsibility.
- ***Coverage changes***. If your insurance changes, please notify us before your next visit so we canmake the appropriate changes to help you receive your maximum benefits.
- ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we mayrefer your account to a collection agency.

__________**INITIAL HERE**

CONSENT TO MEDICAL TREATMENT

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care mayinclude, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medicationadministration, and other procedures considered advisable in my diagnosis, treatment and courseof care.
- I acknowledge that my treatment is intended to address specific illnesses and is not intended as asubstitute for a primary care physician and that no guarantee can be made or has been madeas to the results of treatments or examinations at Metro Atlanta Urology and Pelvic Health Center.
- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, Iconsent to testing for HIV or Hepatitis C & B.

__________**INITIAL HERE**

SIGNATURES

By signing below, I acknowledge that I have reviewed Metro Atlanta Urology and Pelvic HealthCenter's payment policy and consent to medical treatment.

Print name of person signing:________________________________ Relationship to patient:____________________

____ ________________________________

Signature of patient (or guardian) Date

Metro Atlanta Urology
and
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Annual – Financial Policy & Consents

NO SHOW/LATE CANCELATION POLICY

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Metro Atlanta Urology and Pelvic Health Center sends text message and email reminders 1 week, 2 days, 1 day, and 1 hour in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 2 business days notice.

If you do not cancel or reschedule your appointment with at least 2 business days notice, we will assess a $75 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it and will not be allowed to reschedule until the fee is paid. We understand emergencies happen and will waive the fee the first time.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

SIGNATURES

I understand the "no-show" policy of Metro Atlanta Urology and Pelvic Health Center and agree to provide a credit card number, which may be charged $75 for any "no-show" of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 2 business days in advance in order to avoid a potential no-show charge to the credit card provided.

Signature of patient (or guardian)	Date

METRO ATLANTA UROLOGY AND PELVIC HEALTH CENTER

Urologists who listen. Urologists who care.

Patient's Name: ______________________________________ Date:_________________

What is your MAIN COMPLAINT today? ____

____

Choose any other conditions you want to discuss at FUTURE visits (select all that apply)

☐ Blood in the urine (including microscopic)
☐ Constipation or Fecal Incontinence
☐ Ejaculatory issue (premature ejaculation/ hematospermia)
☐ Elevated PSA
☐ Exposed Vaginal Mesh
☐ GU Fistula (including vesicovaginal fistula/rectovaginal fistula)
☐ Hydronephrosis or kidney cyst
☐ Infertility
☐ Kidney/ureter/bladder stone
☐ Low Testosterone
☐ Menopause
☐ Neurogenic bladder
☐ Pelvic organ prolapse (including cystocele/rectocele)
☐ Pelvic or Vaginal Pain
☐ Penile Girth Enhancement
☐ Penile Issue (including balanitis/ phimosis/circumcision consult/ Peyronie's/condyloma)
☐ Sexual or Erectile dysfunction (all genders, including decreased libido and sensation)
☐ Swelling or pain of the scrotum or testicles (including hydrocele, spermatocele, varicocele, epididymitis)
☐ Urinary symptoms (including frequency, urgency, straining, retention, leaking, incontinence, BPH)
☐ Urethral Diverticula
☐ Urethral prolapse/caruncle
☐ Urinary Tract Infection or Prostatitis or Interstitial Cystitis
☐ Vasectomy
☐Labiaplasty/Vaginal Reconstruction
☐Hormone Replacement Therapy
☐ Weight Loss

Other: ____________________________

Metro Atlanta Urology and Pelvic Health Center

Financial Policy

1. Payment Policy:

General payment policies

Accepted Payment Methods: The accepted methods of payments are: cash, personal checks, and all major credit/debit cards. A fee of $15 will be charged for any bounced checks.

Financial Consultation: Depending on the treatment plan discussed with our providers, patients may be required to schedule a financial consultation with our office staff. During this consultation, we will provide a detailed cost estimate for the desired procedure(s) and discuss available payment options.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Late Arrivals: If you arrive more than 45 minutes late for your appointment, we reserve the right to reschedule or shorten the appointment. A late fee of $75 may apply.

Notice Period: Non-surgical appointments require a minimum of 2 business days notice for cancellations or rescheduling. We require a minimum of two weeks' notice for cancellations or rescheduling of out-of-office surgery dates. In-office appointments can be rescheduled without penalty if the change is made outside of the required notice period.

In-office Appointment Cancellations: Canceling/No show or rescheduling an in-office appointment outside the notice period will incur a $75 late fee.

Out-of-office Appointment Cancellations: Canceling/No show or rescheduling an out-of-office appointment outside the notice period will incur a $150 late fee

Miscellaneous: any additional fees or charges will be communicated to you in a timely manner.

Insured Patients

Insurance. We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your government issued ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Copayments and deductibles. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a **$100 collections processing fee** will be added to any outstanding balance.

Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Self-Pay Patients

Clinic visits: Self-pay patients will be charged a flat fee for both new and follow-up clinic visits. Payment is due at the time of service. These fees cover the consultation and examination provided during the visit, but do not include any additional services, treatments, or diagnostic tests that may be recommended.

Discounts: Self-pay patients may be eligible for a 5% discount on the total cost of their procedure(s) if payment is made in full at the time of booking. This discount is not applicable in conjunction with any other promotions or discounts.

Cancellation and Refund Policy: Self-pay patients are subject to the same cancellation and refund policies as our insured patients. Please review our cancellation and refund policies for more information.

Treatment Plan Changes: If a self-pay patient requires additional procedures or treatments not included in the original treatment plan, the patient will be responsible for covering the additional costs. A new financial consultation may be required to discuss these changes.

Procedures and Surgeries

Booking fee In-office procedures require a booking fee of $75 to secure the appointment. At the time of booking, the booking fee amount and payment instructions will be provided to you. The Booking fee is applied to the total owed for the procedure but is non-refundable nor transferable if an appointment is canceled or rescheduled less than 2 business days before scheduled visit.

Deposit: A deposit of 50% of the total cost is required to secure an out-of-office procedure date and is due upon scheduling your procedure.

Full Payment: The remaining balance is due two weeks prior to the scheduled out-of-office surgery date. For in-office procedures, full payment is required on the day of service. All clinic visit payments are due on the day of service.

Service Fee Superbill:

Metro Atlanta Urology and Pelvic Health Center is committed to ensuring that our patients understand the out of pocket costs associated with non-covered services and procedures.

Availability: Our service fee superbill is available upon request. This schedule outlines the physician charges for each procedure we offer.

Physician Charges: The service fee schedule includes physician charges only. These charges cover the professional services provided by our physicians, including the performance of the procedure.

Facility Charges: Please note that facility charges are not included in our service fee schedule. These charges are determined by the individual facility where the procedure is performed and will be billed separately. Facilities may include hospitals, surgical centers, or other medical facilities.

Separate Billing: Any additional services, such as anesthesia, laboratory tests, or additional treatments or procedures, are not included in our service fee schedule and will be billed separately.

2. Credit Card Policy

Authorization: Patients who choose to keep a credit card on file must provide written authorization for Metro Atlanta Urology and Pelvic Health Center to securely store their credit card information and charge the card for outstanding balances. This authorization will remain in effect until it is revoked by the patient in writing.

Secure Storage: Metro Atlanta Urology and Pelvic Health Center is committed to protecting our patients' financial information. Credit card information will be securely stored and encrypted in compliance with the Payment Card Industry Data Security Standard and any applicable laws and regulations.

Usage: The credit card on file will be charged for outstanding balances related to the patient's account, including fees for services, treatments, products, and any other charges agreed upon by

the patient and Metro Atlanta Urology and Pelvic Health Center. This may include copays, deductibles, co-insurance, and any amounts not covered by insurance.

Notification: Metro Atlanta Urology and Pelvic Health Center will notify the patient via text message and/or before charging the credit card on file. The patient will have 48 hours to review the charges and contact our office with any questions or concerns

Receipts: A receipt for the charged amount will be provided to the patient after the transaction has been processed.

Declined or Expired Cards: If the credit card on file is declined or expired, Metro Atlanta Urology and Pelvic Health Center will contact the patient to obtain updated payment information. The patient is responsible for providing updated credit card information promptly.

Revoking Authorization: Patients may revoke their authorization to keep a credit card on file and charge the card for outstanding balances at any time by providing written notice to Metro Atlanta Urology and Pelvic Health Center. Upon receipt of the written notice, Metro Atlanta Urology and Pelvic Health Center will securely remove the credit card information from our system and cease charging the card for future balances.

Opt Out: Patients who opt out of leaving a credit card on file to secure future payments may be required to pay the full allowable visit for a level 4 new or return patient visit at the time of service. Overpayments will be applied to future visits scheduled within 12 months and refunded if no visit is scheduled within the same time frame.

3. Refund Policy:

Refunds: Refunds, minus applicable fees, can be applied to future fees over the next year with the option for return in full after 1 year. Returns can be made at any time minus a card processing fee of $10.

Non-Refundable Payments: Payments for non-surgical treatments and medications are non-refundable.

Refunds for Unsatisfactory Results: Cosmetic procedures do not guarantee specific results. In the event of unsatisfactory results, our practice will evaluate each case on an individual basis and may offer follow-up treatments, revisions, or partial refunds as deemed appropriate. No more than 50% of payment will be returned if a partial refund is deemed appropriate to cover cost of goods and staff time.

Product Refunds: not eligible for refunds.

Metro Atlanta Urology
and
Pelvic Health Center

Fee Table

DESCRIPTION	FEE	PERCENTAGE
Scheduling Fee		
Booking Fee *(in-office procedures)*	$75	
Deposit *(out-of-office procedure)*		50%
Delinquency/Deficiency Fees		
Bounced Checks	$15	
Account turned over to a Collection Agency *(processing fee)*	$100	
Last-minute reschedule (less than 2 business days)/ **cancellation Fees**		
In-office appointments	$75	
Out-of-office procedures	$150	
Late Arrival* (45 min)	$75	
Processing Fees		
Credit Card Refund	$10	

I acknowledge that I have reviewed Metro Atlanta Urology and Pelvic Health Center's Financial Policy and consent to the respective payment.

Print name of person signing: ____

Relationship to patient: ____

_________________________________ Signature of patient (or guardian)

____________________ Date

Metro Atlanta Urology
and
Pelvic Health Center

Narcotic and Opioid Patient Prescriber Agreement (PPA)

- Pain and pain treatment are different for each person. Narcotic and opioid medicines are a type ofmedicine used to reduce moderate to severe pain. Narcotic and opioid medicines can reduce some(but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines.

- My prescriber and I may also try alternative or additional treatment options for my condition, including: Non-opioid medicines, Physical therapy, appropriate exercises, Self-management techniques and coping strategies, or surgical or other medical procedures.

- Using narcotic and opioid medicines may cause:
  - *Physical dependence*: If the medicine is suddenly stopped I may experience withdrawal symptoms.
  - *Tolerance*: Over time, I may need more medicine to get the same pain relief.
  - *Addiction*: I may develop an intense craving for the opioid medicine, even if I take it as prescribed. If someone in my family has been addicted to drugs or alcohol, I may be at greater risk for addiction.

- Narcotic and opioid medicines can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely.

- Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid or narcotic medicine will increase the chance of side effect such as drowsiness, dangerously slowed breathing, and decreased alertness. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away.

- I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine

- I told my prescriber about all the medicines I am taking, including any prescription, over-the-counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future.

- I will tell my prescriber if I am pregnant or planning to become pregnant

- I will not share this opioid medicine with other people.

- I will keep my opioid medicine in a secure place where other people cannot reach it.

- I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself.

- I understand that my prescriber may be required to check the Georgia Prescription Drug Monitoring Program before issuing a prescription for certain narcotics or opiates.

____ Patient Signature

__________________________ Date

Metro Atlanta Urology and Pelvic Health Center

Privacy Policy

PRIVACY NOTICE
METRO ATLANTA UROLOGY AND PELVIC HEALTH CENTER, LLC.

NOTICE OF PRIVACY POLICIES

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

Introduction

At Metro Atlanta Urology and Pelvic Health Center we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective May 1, 2022, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the Metro Atlanta Urology and Pelvic Health Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

1. Basis for planning your care and treatment
2. Means of communication among the many health professionals who contribute to your care,
3. Legal document describing the care you received,
4. Means by which you or a third-party payer can verify that services billed were actually provided.
5. A tool in educating health professionals.
6. A source of data for medical research
7. A source of information for public health officials charged with improving the health of this state and the nation,
8. A source of data for our planning and marketing,
9. A tool, which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Metro Atlanta Urology and Pelvic Health Center, the information belongs to you. You have the right to:

1. Obtain a paper copy of this notice of information practices upon request,
2. Inspect and copy your health record as provided for in **45 CFR 164.528,**
3. Request communications of your health information by alternative means or at alternative locations,
4. Request a restriction on certain uses and disclosures of your information as provided by **45 CFR 164.522,** and
5. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Metro Atlanta Urology and Pelvic Health Center is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction, and
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in our offices. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of Disclosures for Treatment Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: These are some services provided in our organization through contacts with a business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill your or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representation, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research proposal has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Metro Atlanta Urology and Pelvic Health Center's Privacy Officer, Bryan Rivera, at (678) 528-0578. If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Humans Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 500F, HHH Building
Washington, D.C. 20201

Signature: ______________________________________

Print Name: ____________________________________

Date: ____