Buckhead Rheumatology

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Atlanta, Georgia 30305

P: 404-355-1799 F: 404-355-4788

Dear New Patient,

Thank you for trusting the providers at Buckhead Rheumatology to care for your Rheumatological needs. For your initial visit, patients typically see both Dr Singh and a Physician Assistant (PA). For subsequent visits, we utilize a singular schedule, which means, throughout the course of your care you will be seen by any one of the three providers at our practice.

We recommend filling out the new patient paperwork in advance of your appointment. If you are unable to do so, please arrive 20 minutes earlier for your appointment to complete the forms. To assess your medical needs, please answer all questions pertinent to you. Please make sure you bring the following with you to your appointment:

1. List (or actual bottles) of ALL medications, including dosing instructions and pharmacy name and phone number.
2. Name of your referring physician and PCP, if your insurance policy requires a referral, please bring the referral with you.
3. Your insurance card, photo ID and be prepared to pay applicable deductible, coinsurance or copay on your visit.
4. Please bring any pertinent medical records, these include but are not limited to lab tests, imaging (i.e. reports of -rays, MRI's, CT scans, bone density scans) which may be related to your condition. It is best if you ask your referring physician to forward this information before your visit.
5. The parking deck for our building is a credit card only.

Buckhead Rheumatology uses the secure patient portal My Chart through Piedmont Hospital. Once your account is established, you can cancel appointments, request medication refills, view lab results, send and receive secure messages with our staff.

Kindly notify us 24 hours in advance if you are unable to keep your appointment. This allows us to provide care to other patients in need of an appointment. We reserve the right to charge a fee of $60 for all missed appointments. This fee is not covered by insurance and must be paid prior to your next appointment.

We look forward to meeting you.

Sincerely,

The Staff at Buckhead Rheumatology

Buckhead Rheumatology

Medical History

Full name: _____ Date of birth: _____ Date: _____

Primary Doctor: _____

Doctor who requested today's visit: _____

List current/previous doctors and their specialty: _____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, include non-prescription, supplements, herbs, birth control)

_____

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ❑ Alcohol/Drug addiction
- ❑ Anemia
- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorder
- ❑ Blood clot
- ❑ Blood Transfusion
- ❑ Crohn's disease
- ❑ COPD/Emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Gerd
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart murmur
- ❑ Hepatitis B or C
- ❑ High cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Seizure
- ❑ Sickle cell disease
- ❑ Sjogren's Syndrome
- ❑ Sleep apnea
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcerative colitis
- ❑ Other: _____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ❑ Adopted

Family Members		Major Medical Problems	If Deceased, Causes	
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Mother				
Father				
Brothers and Sisters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			
Sons and Daughters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			

SOCIAL HISTORY

Occupation: Marital Status: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke? ❑ Yes ❑ No Packs per day: ❑ ¼ pack ❑ 1½ packs How many years? _____

Are you a former smoker? ❑ Yes ❑ No ❑ ½ pack ❑ 2 packs Year quit? _____

Do you chew tobacco? ❑ Yes ❑ No ❑ 1 pack ❑ Other:

_____

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?

Advanced Directive for Healthcare

Review of symptoms (please check if you have recently had the following symptoms):

- ❑ Weight gain
- ❑ Weight loss
- ❑ Night sweats
- ❑ Weakness
- ❑ Fatigue
- ❑ Insomnia
- ❑ Change in vision
- ❑ Fever
- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Chest pain
- ❑ Palpitations
- ❑ Fainting
- ❑ Difficulty swallowing
- ❑ Indigestion or heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ Joint Pain (location)
  - ❑ Hand ❑ Wrist
  - ❑ Back ❑ Neck
  - ❑ Elbow ❑ Shoulder
  - ❑ Hip ❑ Knee
  - ❑ Ankle ❑ Foot

  _____
- ❑ Blood in stool
- ❑ Frequency of urination
- ❑ Dry Eyes
- ❑ Dry Mouth
- ❑ Abnormal Lab
- ❑ Anxiety
- ❑ Depression
- ❑ Feeling too hot
- ❑ Feeling too cold
- ❑ Dizziness
- ❑
- ❑ Headaches
- ❑ Memory loss
- ❑ Numbness/Tingling
  - ❑ Hand ❑ Wrist
  - ❑ Back ❑ Neck
  - ❑ Elbow ❑ Shoulder
  - ❑ Hip ❑ Knee
  - ❑ Ankle ❑ Foot
- ❑ Skin Rash
- ❑ Other: _____

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

_____ _____ _____ _____

Patient/Designee Signature | Patient Name (Print) | Date (MM/DD/YY) | Time

_____ _____

Relationship to Patient | Reason Patient is Unable to Sign

Buckhead Rheumatology

Patient Registration

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ **Nickname** _____ **Sex:** ❑ Male ❑ Female

Date of birth _____ **Social security number** _____ **Race** _____ **Preferred language** _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Marital status**: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Email: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ❑ **Same as patient**

Full legal name (First, Middle, Last, suffix) _____ **Date of birth** _____ **Social security number** _____

Relation to patient: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____ **Sex**: ❑ Male ❑ Female

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ❑ **Self-pay (no insurance)**

Primary insurance: _____ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary insurance: _____ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer size**: ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ❑ **Yes or** ❑ **No**

Not a Part of the Legal Medical Record

Buckhead Rheumatology
Financial Policy

Thank you for choosing **Buckhead Rheumatology** as your health care provider. We are committed to building a successful physician-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our Practice Manager.

When are payments due?
All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator.

How may I pay?
We accept payment by cash, check, debit, most major credit cards

Do I need a referral or pre-authorization?
If your insurance plan requires a referral authorization from your primary care physician or a pre-authorization from your insurance, you will need to contact your primary care physician or insurance company to be sure it has been obtained. If we have yet to receive authorization prior to your appointment time, we will reschedule. Failure to obtain the referral or preauthorization may result in a lower or no payment from the insurance company, and the balance will become the patient's responsibility.

Will you bill my insurance?
Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. We will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information.

It is your responsibility to notify our office promptly of any patient information changes (ie, address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Which plans do you contract with?
Buckhead Rheumatology accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

What is my financial responsibility for services?
It is your responsibility to verify that the physicians and the practice where you are seeking treatment are listed as authorized providers under your insurance plan. Your employer or insurance company should be able to provide a current provider listing.

Do you charge a penalty for returned payments?
Any charges incurred by the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card chargebacks, or returned payments will attract a minimum $60 penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?
We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

I have a hardship. How can you help me?
Some patients may accrue large balances for services provided. At the sole discretion of the practice leadership, we will work with you to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will need proof of financial hardship.

Do you charge for completing forms?
Completing disability forms, FMLA forms, and other requested supplemental insurance forms requires time away from patient care and day-to-day business operations. A prepayment of $15.00 per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the physician, some of these forms can be quite complicated and tedious to fill out. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 7 business days for this process.

Do you charge for copies of medical records?
Patients requesting copies of their medical records will not be charged a fee. Attorneys and Insurance companies requesting medical records will be charged.

What if I missed my appointment to see the physician?
We understand that on rare occasions, issues may arise, causing you to miss your appointment when you cannot notify our office before your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to having it rescheduled.

Our highly skilled physicians are committed to your well-being and have reserved time just for you. Patients who miss more than one appointment without notifying our office 24 hours before the appointment time are subject to a $60 missed appointment fee billed to the patient.

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by Buckhead Rheumatology to simplify insurance reimbursement for the services provided to me.

Patient or authorized representative signature: _____ **Date:** _____

Patient or authorized representative name: _____

Buckhead Rheumatology

General Consent for Care and Treatment Consent

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 to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The 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 physician 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 examination, 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 Representative	**Date:**
Printed Name of Patient or Representative	**Relationship to**

Buckhead Rheumatology

Release of Information

Patient Name: _____

Patient Date of Birth: _____

I authorize Buckhead Rheumatology to release medical information to my referring doctor, health agency, government agency, insurance company, laboratory, pharmacy, hospital or medical facility.

I authorize any physician, hospital or clinic to provide details of medical history to Buckhead Rheumatology.

With this consent, Buckhead Rheumatology may call and leave a message on my cell, work or home number in reference to appointment reminders, insurance items, and clinical care.

Medical information can be disclosed to the following persons:

Name: _____ Phone Number_____

Name: _____ Phone Number_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specified information to be released may include but it is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. The authorization will expire in one year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____

Signature: _____

Buckhead Rheumatology

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION PURSUANT TO FEDERAL REGULATIONS. PLEASE REVIEW IT CAREFULLY.

At Buckhead Rheumatology, we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive directly from one of our physicians. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices ("Notice") applies to all the records of your care generated by Practice.

This Notice will tell you about the ways in which Buckhead Rheumatology may use and disclose your protected health information ("PHI"). This Notice also describes your rights and certain obligations Buckhead Rheumatology has regarding the use and disclosure of PHI.

REGULATORY REQUIREMENTS

Buckhead Rheumatology is required by law to maintain the privacy of your PHI, to provide individuals with notice of Practice's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect.

RIGHTS.

You have the following rights regarding your PHI:

Restrictions

You may request that *Buckhead Rheumatology* restrict the use and disclosure of your PHI. To request restrictions, you must make your request in writing to our Privacy Officer using the applicable *Buckhead Rheumatology* form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications

You have the right to request that communications of PHI to you from *Buckhead Rheumatology* be made by means or at locations. For instance, you might request that communications be made to your work address, instead of your home address. Your requests must be made in writing using Buckhead Rheumatology's form and sent to the Privacy Officer. *Buckhead Rheumatology* will accommodate your reasonable requests.

Inspect and Copy

Generally, you have the right to inspect and copy your PHI that *Buckhead Rheumatology* maintains, provided you make your request in writing to Buckhead *Rheumatology's* Privacy Officer. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If *Buckhead Rheumatology* does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

Amendment.

If you believe that your PHI maintained by *Buckhead Rheumatology* is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI. We can deny your request if your request relates to PHI: (i) not created by *Buckhead Rheumatology* (ii) not part of the records Buckhead *Rheumatology maintains*; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and *Buckhead Rheumatology's* denial attached; and (iii) complain about the denial.

Accounting of Disclosures.
You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment and health care operations; (ii) made to you; (iii) for Buckhead Rheumatology's *patient* list; (iv) for national security or intelligence purposes; or (v) to law enforcement officials. You should submit any such request to Buckhead Rheumatology's *Privacy* Officer. Practice will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of the costs of providing the list.

Right to Copy Notice
You have the right to receive a paper copy of this notice upon request. To obtain a paper copy of this notice, please contact the Privacy Officer at the address and contact information stated at the end of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

Buckhead Rheumatology may use or disclose your PHI for the purposes described below without obtaining written authorization from you. In addition, Buckhead Rheumatology and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

For Treatment.
Buckhead Rheumatology may use and disclose PHI while providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider.

For Payment.

Buckhead Rheumatology may use and disclose PHI to bill and collect payment for the health care services provided to you. For example, Practice may need to give PHI to your health plan to be reimbursed for the services provided to you. Practice may also disclose PHI to its business associates, such as billing companies, claims processing companies and others that assist in processing health claims. Buckhead Rheumatology may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations.

Buckhead Rheumatology may use and disclose PHI as part of its operations, including for quality assessment and improvements, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, credentialing and peer review activities, and health care fraud and abuse detection or compliance, and management and administration. Buckhead Rheumatology may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants and others for review and learning purposes, to help make sure Buckhead Rheumatology is complying with all applicable laws, and to help Buckhead Rheumatology continue to provide quality health care to its patients.

As Required by Law and Law Enforcement
Buckhead Rheumatology may use or disclose PHI when required to do so by applicable laws and when ordered to do so in a judicial or administrative proceeding. Buckhead Rheumatology may also use or disclose PHI upon a properly documented and limited request from law enforcement agencies.

For Public Health Activities and Public Health Risks
Buckhead Rheumatology Buckhead Rheumatology may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, or notifying a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities
Buckhead Rheumatology Practice may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors
Buckhead Rheumatology may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Research
Under certain circumstances, Buckhead Rheumatology may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication with those who received another, for the same condition.

To Avoid a Serious Threat to Health or Safety

Buckhead Rheumatology may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions.

Buckhead Rheumatology may use and disclose PHI of military personnel and veterans under certain circumstances. Practice may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the president or other authorized persons or foreign heads of state or to conduct special investigations.

Disclosures to You or for HIPAA Compliance Investigations.

Buckhead Rheumatology may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. Buckhead Rheumatology must disclose your PHI to the secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary to investigate Buckhead Rheumatology's compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

Patient List; Marketing

Unless you object, Buckhead Rheumatology may use some of your PHI to maintain a list of patients it has served. This information may include your name, treatment facility, and the services Practice provided to you. This patient list and the information on it may be used for marketing purposes.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care.

Unless you object, Buckhead Rheumatology may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care.

OTHER USES AND DISCLOSURES.

Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations; you have the right to revoke your authorization in writing. If you revoke your authorization, Buckhead Rheumatology will no longer use or disclose PHI about you for the reasons covered in your written authorization. Please understand that Buckhead Rheumatology is unable to recover any disclosures already made with your authorization, and that Buckhead Rheumatology is required to retain records of the care provided to you.

RIGHT TO FILE A COMPLAINT.

At Buckhead Rheumatology, we value the relationships we develop with our patients, our patients' privacy, and the trust our patients' have in us. As such, we make every effort to remedy any issues or concerns you may have. You may submit any complaint regarding your privacy rights to: Privacy/Security Officer Rattandeep Singh, MD

You also have the right to file a complaint with the secretary of the Department of Health and Human Services, Office for Civil Rights. You will not be penalized for filing a complaint. You may contact the Office for Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services
Information for regional offices

PLEASE CONTACT THE PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OF PRIVACY PRACTICES OR YOUR PRIVACY RIGHTS.

Patient or authorized representative signature: _____ Date: _____

Patient or authorized representative name: _____