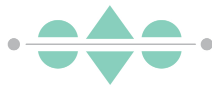


Aspire PDX

PATIENT INTAKE: MEDICAL HISTORY

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name: ____

Address: ____

Phone: (w) ______________ (h) ______________ (c) ______________

DOB: ______________ Age: ________Email : ______________

Emergency contact: ____

Relationship to patient: ______________ Phone: ______________

Primary care physician: ______________ Phone: ______________

Date of last physical: __________ Have you ever had an EKG? ( ) N ( ) Y Date: __________

Current or past medical conditions (check all that apply) :

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) Gastrointestinal bleeding
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems (like hepatitis)
( ) Pancreatic problems
( ) Thyroid disease
( ) Sexually transmitted diseases
( ) Abnormal Pap smear
( ) If female, currently pregnant
( ) Anxiety
( ) Depression
( ) PTSD
( ) ADHD
( ) Chronic pain

Other (Please describe) : ____

Have you ever had **surgery** or been **hospitalized for any reason**? ( ) N ( ) Y (Please describe)

____

____

Have you ever been diagnosed with a **psychiatric** or **mental illness**? ( ) N ( ) Y (Please describe)

____

Are you currently seeing a psychiatrist or mental health provider? ( ) N ( ) Y Name:______________________

Have you ever taken or been prescribed **antidepressants**? ( ) N ( ) Y For what reason ____________________

Medication(s) and dates of use: ________________________________ Why stopped: ________________________

Are you currently considering harming yourself, or having suicidal thoughts? ( ) N ( ) Y

Have you ever been the victim of emotional, sexual, or physical abuse? ( ) N ( ) Y

MD NOTES: ____

____

____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).
DO NOT include medications you may be currently misusing (that information is needed later): _______________

____

____

Please list all current **herbal medicines**, **vitamin supplements**, etc, and how often you take them: _____________

____

MD NOTES: ____

____

____

Please list any **allergies** you have (eg, penicillin, bees, or peanuts): ____

Have you ever been **treated for substance misuse**? ( ) N ( ) Y (Please describe when, where, how long)

____

____

MD NOTES: ____

____

____

____

Substance Use History

	No	Yes/Past or Yes/Now	Route (oral, injection, snorting)	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Prescription pain medications							
Methadone							
Heroin							
Suboxone (buprenorphine)							
Tramadol							
Cocaine							
Amphetamines or methamphetamine							
MDMA (Ecstasy)							
LSD or hallucinogens							
Tranquilizers/ Sleeping Pills (Valium, Ambien)							
PCP							
Stimulants (Ritalin)							
Alcohol							
Marijuana							
Tobacco							

Tolerance
Dependence
Desire to cut down but can't
Cravings
Great deal of time spent obtaining
Affecting home, work, or school life
Giving up social, occupational, or other activities
Using under circumstances when hazardous
Continuing to use even though it is causing physical or psychological problem

MD NOTES: ____

____

Are you currently experiencing any withdrawal symptoms (circle)?:

Palpitations	Runny nose	Yawning	Muscle/joint aches
Sweating	Stomach cramps	Anxiety/irritability	
Restlessness	Tremor	Goosebumps	

What was your longest period of abstinence? ______________________________

What do you think helped you to be abstinent from drugs? ______________________

____

Have you ever been hospitalized or treated in an emergency room for withdrawal symptoms? ( ) N ( ) Y

Have you ever overdosed? **(** **)** N **(** **)** Y Substance: ______________________

Have you ever sold or traded illicit or prescription drugs with another person? **(** **)** N **(** **)** Y

Do you know anyone who is currently taking Suboxone (buprenorphine)? **(** **)** N **(** **)** Y

Do you live with anyone who is addicted to drugs, or being treated for addiction? **(** **)** N **(** **)** Y

Have you ever been arrested for a drug or alcohol –related offense? ( ) N ( ) Y (Please describe)

____

Are you currently on parole or probation? ( ) N ( ) Y (Please describe, including P.O.)

____

Have you ever injured yourself or someone else while under the influence of drugs? ( ) N ( ) Y (describe)

____

Are you receiving, or have you ever received counseling support? **(** **)** N **(** **)** Y (Please describe when and for how long) ____

MD NOTES: ____

____

____

____

Social History

Marital status

( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) In a long-term relationship

Does your spouse or partner use drugs? ( ) N ( ) Y

Children:(ages)____

Children live with:____

Living environment (check all that apply)

( ) own a home ( ) rent a home or apartment ( ) living with friends or family ( ) homeless

Do any of your family members have problems with addiction? To what substances?

____

Has your use of drugs had a negative impact on your relationships with friends or family? ( ) N ( ) Y

MD NOTES: ____

____

Employment status:

( ) currently working ( ) unemployed ( ) disabled

Type of employment:____

Hours per week:____

Has your use of drugs ever resulted in discipline or termination of employment? **( )** N **( )** Y

Has your use of drugs ever resulted in missed work time, or accidents at work? ( ) N ( ) Y

How many days of the week do you exercise?: ______ How long do you exercise:________Activity:___________________

MD NOTES: ____

____

Review of Current Symptoms (circle any symptoms you are currently experiencing):

General:	fever	chills	weight loss	night sweats
Heart:	chest pains	heart palpitations	fainting	
Lungs:	wheezing	cough	shortness of breath	
GI:	constipation	blood in stool		
Neuro:	weakness	dizziness	difficulty concentrating	numbness

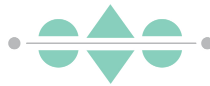
Extremities: swelling rash

In your own words, why are you interested in seeking treatment?

____

____

____



Aspire PDX

PATIENT TREATMENT AGREEMENT

Patient Name: ____ Date: __________________

As a participant in medication treatment for a substance use disorder, I freely and voluntarily agree to accept this treatment agreement as follows:

1. I agree to keep and be on time for all scheduled appointments. I agree to pay a $50 fee for missed appointments (no shows) or late cancellations (<24 hours of appointment). I agree to authorize having a credit card on file for payment of services or missed appointments/late cancellations.

2. I agree to adhere to the office's payment policies, and I understand that Aspire PDX does not bill or contract with health insurance (including Medicare and Medicaid). I understand I will be responsible for paying any services I receive, and payment for services is due at the time of the appointment. I understand that Medicare and Medicaid (Oregon Health Plan) will not reimburse me for services provided at this office, and I will not seek reimbursement from them for services provided by Aspire PDX. I understand that Medicaid (Oregon Health Plan) will not pay for the cost of medications prescribed by Dr. Sudakin. I understand that the cost of medications and laboratory confirmation testing is separate from fees for services provided at this office.

3. I agree to update the office in the event that there are any changes in my contact information (address, email, phone), insurance coverage, or overall medical conditions.

4. I agree to not come to the office outside of usual business hours, or at times I do not have a scheduled appointment to be seen. If I arrive after my scheduled appointment time, I will not be seen until the next open time slot.

5. I agree to not use text messaging or non-secured email messages to communicate with the office. Patients who wish to use secure messaging with the office should use the patient portal (Patient Fusion).

6. I agree to arrive 10 minutes before my scheduled appointment time, and will be prepared to provide a urine specimen or oral fluid test *before* my office visit.

7. I agree to conduct myself in a courteous manner in the doctor's office. Examples of disruptive activities include using rude, profane or inappropriate language when communicating with staff, and requests for early refills of medications.

8. I agree not to sell, share, hoard, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and will result in my treatment being terminated without any recourse for appeal.

9. I will not tamper with, attempt to dilute or substitute, or do anything that would intentionally affect the results of urine or oral fluid testing. I understand that failure to adhere to this policy is a serious

violation of this treatment agreement.

10. I agree not to deal, steal, or conduct any illegal activities in the doctor's office. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected at the office or by the pharmacy where my medication is filled, it will result in my treatment being terminated.

11. I agree that my medication/prescription can only be given to me at my regular office visits. A missed appointment or late cancellation will result in my not being able to get my medication/prescription until the next scheduled visit.

12. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication is a serious violation of this treatment agreement.

13. I agree not to obtain controlled substance medications from any doctors, pharmacies, or other sources without consulting with and informing this office.

14. I agree that as part of the monitoring of my treatment, the doctor will consult the Oregon Prescription Drug Monitoring Program database.

15. I agree that as part of the monitoring of my treatment, the doctor or his staff may conduct pill (or medication strip) counts at my office visits, or at random. I agree to bring any unused prescribed medications with me to every office visit.

16. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events involving medications that are prescribed to me.

17. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

18. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling and/or other recovery support activities as discussed and agreed upon with my doctor and specified in my treatment plan. I have been counseled about the use of naloxone (Narcan) and will discuss with my family and pharmacist.

19. I agree and understand that buprenorphine is being used to the treatment of opioid dependence, and not for the management of acute or chronic pain. I agree and understand that my doctor does not treat chronic pain, and he will refer me to a pain specialist if needed or requested.

20. I agree and understand that my doctor is treating me for opioid dependence, and is not providing primary care services.

21. I agree that the treatment goal is to abstain from all addictive substances and drugs of abuse.

22. I understand that violations of this treatment agreement may result in termination of treatment.

_______________________________________ ________________________

Patient Signature Date

INFORMED CONSENT:
BUPRENORPHINE TREATMENT OF OPIOID DEPENDENCE

Suboxone® (a film containing buprenorphine and naloxone) is an FDA approved medication for treatment of people with heroin or other opioid addiction. There are also other formulations that are FDA-approved, including Bunavail, Zubsolv, and generic buprenorphine/naloxone tablets. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate and/or opioid addiction, including methadone, naltrexone, and some treatments without medications that include counseling, and peer support groups. My doctor has explained all of these treatment options to me.

If you are dependent on opioids or opiates, you need to be in as much withdrawal as possible when you take the first dose of buprenorphine. My doctor will tell me how long I will have to abstain from opioids or opiates before my first dose (induction). **It you are not in withdrawal, buprenorphine can cause severe opiate withdrawal.** The doctor will counsel you on the induction process, and if you are having an in-office induction you should plan to remain in the office for at least 2 hours. We recommend that you arrange not to drive after your first dose, because some patients get drowsy until the correct dose is determined for them. You should not drive, operate heavy machinery, or do safety-sensitive work until you have adjusted to the effects of the medication. This may take several days or longer.

Some patients find that it takes several days, in some cases several weeks, to get used to the transition from the opiate they had been using to buprenorphine. For this reason, regular follow-up visits with the doctor are required, to monitor progress with the treatment plan during the stabilization period. After you become stabilized on buprenorphine, it is expected that the use of other opiates will have less effect. Attempts to override the buprenorphine by taking more opiates or opioids could result in an overdose. You should not take any other medication without discussing it with the physician first.

Combining buprenorphine with alcohol or other sedating medications can be very dangerous, especially during the induction and stabilization phases. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.), especially during the induction and stabilization period, has resulted in deaths.

The form of buprenorphine (Suboxone®) you will be taking is a combination of buprenorphine with a short-acting opiate blocker (Naloxone). It will maintain physical dependence, and if you discontinue it suddenly, you will likely experience withdrawal. If you wish to discontinue treatment with buprenorphine, you will need to discuss this with your doctor to develop a plan for a gradual taper.

Buprenorphine sublingual films or tablets must be held under the tongue until they dissolve completely. It is important not to talk or swallow until the film or tablet dissolves. This takes up to ten minutes. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed. If you swallow the film or tablet, you will not have the important benefits of the medication, and it may not relieve your

withdrawal.

If you are transferring to buprenorphine from methadone maintenance, your dose has to be tapered until you have been below 30mg for at least a week. There must be at least 24 hours (preferably longer) between the time you take your last methadone dose and the time you are given your first dose of buprenorphine. Your doctor will examine you for clear signs of withdrawal, and you will not be given buprenorphine until you are in withdrawal.

I have read and understand these details about risks and benefits of buprenorphine treatment. I wish to be treated with buprenorphine.

Signed ____Date _____________

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I, ____,
[patient's name]

authorize Daniel L. Sudakin, MD, MPH

to disclose substance use disorder (SUD) diagnosis and treatment information, or referral information

to ____ [name of individual(s) or entity(ies) who will receive the information]

for the purpose of ____.
[describe the purpose of the disclosure; should be as specific as possible]

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: ____.
[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: ___________ __________________________ Signature of Patient

__________________________ Signature of person signing form if not patient

Describe authority to sign on behalf of patient: ___________________________________

Date revoked: ______________________

Staff initials:

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the

release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

42 CFR 2.32 (Updated July 2020); *see* Confidentiality of Substance Use Disorder Patient Records, 85 Fed. Reg. 42986, 43037 (July 15, 2020), https://www.federalregister.gov/d/2020-14675/p-644.

Daniel L Sudakin, MD, MPH, LLC
Notice of Privacy Practices
Acknowledgement

A **NOTICE OF PRIVACY PRACTICES** is provided to all patients on their first visit. This Notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information; to request an accounting of disclosures of your medical information and to request addition restrictions on our uses and disclosures of that information. It explains your rights to complain if you believe your privacy rights have been violated, and our responsibilities for maintain the privacy of your medical information, and letting you know if that privacy is breached

By signing below, I acknowledge that I received a copy of Daniel Sudakin, MD, MPH, LLC's most recent Notice of Privacy Practices.

Signature:____

Date:____

Patient's Printed Name:_____________________________________

Authorized Representative's Name (if applicable):___________________

Authorized Representative's Relationship (if applicable):_______________

Daniel L Sudakin, MD, MPH, LLC
Patient Request for Email Communications

I understand that as a patient at Daniel L Sudakin, MD, MPH, LLC (Aspire PDX), I may request that the Clinic communicate with me via email. I understand that the Clinic provides this service as a courtesy to me only after I have carefully reviewed and completed this form.

I understand that email presents inherent privacy risks. Email is typically sent without encryption, and unencrypted emails can be viewed and read by others while the email is in transit or when the email is stored on my computer or other electronic device. I also understand that errors can occur in transmission, despite the reasonable caution of the sender. As a result, I understand that there is no assurance of confidentiality when information is communicated via email. I understand that the preferred method of e-mail communications with Aspire PDX is through the patient portal (PatientFusion), and I have been given an opportunity to enroll in the portal using my email address.

I also understand that any emails I send to the Clinic may be forwarded for the purposes of providing me treatment or securing payment for my care, and that these emails may become part of my medical record.
I understand that I can request that the Clinic stop communicating with me via email at any time.
I request that the Clinic communicate with me at the following email address:
Email Address: ____

I request that the Clinic communicate with me at this email address only about the following topics (check all that apply):
o Scheduling and Appointments
o Billing and Payment
o Symptoms, Diagnoses, and Treatment
o All of the Above

By signing below, I show that I understand that there are inherent risks associated with email communication, and I authorize Daniel L Sudakin, MD, MPH, LLC to communicate with me regarding my health care and protected health information via email. I agree to hold the Clinic and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request.

Signature: _____________________________________**Date:** ___________________

Printed Name:__________________________________

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other ____

Cardholder Name (as shown on card): ____

Card Number: ____

Expiration Date (mm/yy): ____

Cardholder ZIP Code (from credit card billing address):

____

I, ________________________________, authorize ___________________________________ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

____

Customer Signature Date

Daniel L Sudakin, MD, MPH, LLC

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.

Health information which we receive and/or create about you, personally, relating to your past, present, or future health, treatment, or payment for health care operations, is “protected health information” under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164. The confidentiality of alcohol and drug abuse patient records maintained by this office is protected by another Federal law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally, we may not disclose to a person outside of this office that you are receiving treatment, or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal law. Your health information is further protected by any pertinent state law that is more protective or stringent then either of these two Federal laws.

This Notice describes how we may use and disclose this information. This Notice also describes your rights with respect to protected health information and how you can exercise those rights.

Uses and disclosures that may be made of your health information:

• **Treatment:** We may use your health information and share it with other professionals who are treating you. For example, we may share information with other professionals providing you care.

• **Payment:** We will use and disclose your health information to bill and receive payment for the treatment and services we provide to you. For example, we may disclose your protected health information to your insurer to bill for services provided, or to request prior authorization for medications.

• **Health Care Operations:** Your protected health information may be shared within our clinic for normal business operations including quality assurance. For example, your information may be disclosed to internal staff for evaluating whether our business processes are efficient.

• **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of this clinic, that assist our clinic in providing health care. Examples of qualified service organizations and/or business associates include billing companies, data processing companies, or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this clinic through terms detailed in a written agreement.

• **To Avert A Serious Threat to Health or Safety:** We may disclose your health information when necessary to prevent a serious threat to your health and or the health or safety of the public or another person.

• **Research:** Under certain circumstances, this office may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one test or treatment to those who received another, for the same condition. All research projects, however, must be approved by an Institutional Review Board, or other privacy review board as permitted within the regulations, that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

• **Health Oversight Activities:** This clinic may disclose protected health information to regulatory agencies, funders, third-party payers, and peer review organizations that monitor alcohol and drug

programs to ensure that the clinic is complying with regulatory mandates.

• **Judicial Proceedings:** This clinic may disclose your protected health information pursuant to an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determinations as outlined in the Federal regulations and limits the scope of the disclosure.

• **Crime on Clinic Premises or Against Clinic Personnel:** This clinic may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the clinic premises or against clinic personnel.

• **Suspected Abuse and Neglect:** This clinic may report suspected abuse or neglect as mandated by state law.

• **Public Health Activities:** We may disclose your protected health information for public health reason to a public health authority that is authorized by law to collect or receive such information for reasons such as reporting or controlling disease, public health surveillance, reactions to medications, or product safety.

• **As Required By Law:** This clinic will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

• **Military and Veterans Activities:** If you are or were a member of the military, or part of the intelligence or national security communities, we may be required to release information about you to military command or other government authorities. We may be required to release information about foreign military personnel to the appropriate foreign military authority.

• **Workers' Compensation:** We may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

• **Appointment Reminders:** This clinic reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

• **Family and Friends:** We may disclose your health information to family and friends if we obtain your verbal agreement or provide you with an opportunity to object to the disclosure and you do not. We may also disclose information to your family and friends when the circumstances indicate that you would not object. For example, if you bring a friend or family member to a treatment session. If, an emergency arises and you are unable to consent, we may use our professional judgment to determine whether disclosure to a family member of friend is in your best interest.

• **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice, will be made only with your written authorization or that of your legal representative. If you or your legal representative authorizes us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on the authorization.

• **Psychotherapy Notes:** Psychotherapy notes are those notes recorded by your mental health provider documenting or analyzing the contents of conversations with you, your family, or others during counseling sessions. These are not part of your health record and may only be disclosed with your written authorization.

Your rights regarding protected health information we maintain about you:

• **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit your request in writing to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing, or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial to any part or parts of your request. Some denials, by law, are reviewable, and you will be notified regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in the law, are not reviewable. Each request will be reviewed individually, and a response will be provided to you in accordance with the law.

• **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:

a) Is accurate and complete;
b) Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
c) Is not part of the protected health information kept by or for us; or
d) Is not part of the protected health information, which you would be permitted to inspect and copy.

If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial and/or how you may request that your request to amend and a copy of the denial be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.

• **Right to an Accounting of Disclosures:** You have the right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment, or health care operations within our clinic, or made pursuant to your authorization or made directly to you pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions:** You have the right to request a restriction or limitation on protected health information we are permitted to use or disclose about you for treatment, payment or health care operations within our clinic or made pursuant to your authorization. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your health. If you pay for services out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will honor the request unless we are required by law to share the information.

• **Right to Request Confidential Communications:** You have the right to request that we

communicate with you about protected health information in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, please contact Dr. Daniel Sudakin.

Alternatively, you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697

You may also file a report online at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

Our responsibilities:

This office is required to:

a) maintain the privacy of your health information;
b) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
c) abide by the terms of this Notice; and
d) notify you if there is a breach of your unsecured protected health information.

We reserve the right to change our policies and practices and to make the new provisions effective for all protected health information we maintain at any time. We will post a copy of the current Notice in our office, reflecting the effective date of the Notice at the end of the Notice.

We will not use or disclose your health information without your authorization, except as described in this notice.

To receive additional information:

For further explanation, please contact Dr. Daniel Sudakin at (503) 894-9258.

Availability of Notice of Privacy Practices:
This notice will be posted where registration occurs and/or in Dr. Sudakin's office. You have a right to receive a copy of this notice, and all individuals receiving care will be given a hard copy.

Effective Date: December 1, 2020

Discrimination is Against the Law

Daniel L Sudakin, MD, MPH, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Daniel L Sudakin, MD, MPH, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Daniel L Sudakin, MD, MPH, LLC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - If you need these services, contact Daniel Sudakin.

If you believe that Daniel L Sudakin, MD, MPH, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Daniel Sudakin, 9370 SW Greenburg Rd, Suite 201, Portland, OR 97223, Phone: (503) 894-9258, Fax: (888) 307-3066, email: aspire@aspirepdx.com . You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Sudakin is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.