

Robert Fitton, MD/ Brookfield Primary Care, LLC
REGISTRATION FORM

(Please Print)

Today's Date:				PCP:						
PATIENT INFORMATION										
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status:				
						Single <input type="checkbox"/>	Mar <input type="checkbox"/>	Div <input type="checkbox"/>	Sep <input type="checkbox"/>	Wid <input type="checkbox"/>
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home phone #: ()		Cell phone #: Preferred ? <input type="checkbox"/> Yes ()		Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:				Social Security no. (optional):						
P.O. box:		City:			State:		ZIP Code:			
Occupation:		Employer:				Employer phone no.: ()				
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan		<input type="checkbox"/> Hospital		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other						
Other family members seen here:										

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of primary insurance					
Subscriber's name:		Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	

	Original Date:	
	Dates Revised:	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <small>(Last, First, M.I.):</small>		<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:	
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Previous or referring doctor:			Date of last physical exam:		

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio				
Immunizations and dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox Shingles		
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <small>Measles, Mumps, Rubella</small>		

List any medical problems that other doctors have diagnosed

<input type="checkbox"/> Allergies	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes	List Other	
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypothyroidism		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Coronary Disease	<input type="checkbox"/> GERD		
	<input type="checkbox"/> Parkinson	<input type="checkbox"/> Stroke			

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		Grandmother			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Paternal</i>			

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Office Policies

Please read the following carefully and sign below when complete. If you do not understand a particular policy, please ask our staff for clarification.

Assignment/Financial. Balances and Co-payments:

- ❖ I authorize my insurance company to pay medical benefits directly to my physician for services provided in the office.
- ❖ I understand that I am responsible for any co-payments, deductibles, non-covered services and/or unpaid balance. This applies to all insurance programs including MEDICARE.
- ❖ All balances should be paid within 30 days. Accounts with balances greater than 30 days are subject to interest allowed by law.
- ❖ For accounts with balances over 90 days, patients will be discharged from the practice and the account will be turned over to a collection agency.
- ❖ Co-payments are payable at the time of visit, unless arrangements are made in advance.
- ❖ Any "billed" co-payments, will be assessed a \$10 surcharge.

Referrals

- ❖ If your insurance policy requires "referrals" (prior authorization to see a specialist or get tests):
- ❖ The physician has the right to evaluate the patient before a referral is authorized and the referral process takes 2 to 3 working days.
- ❖ Referral authorization **cannot** be backdated, it is the responsibility of the patient to ensure referrals are in place at the time of referred visits or services are rendered.

Prescription Refills

- ❖ Prescription refill request take 24-48 hours to process and are refilled during office hours only.
- ❖ Many medications require monitoring of the patient and/or their laboratory functions. The follow-up interval and the length of prescription will be determined by the physician.

Form Completion Fees

- ❖ There is a \$25 fee (not covered by insurance) for completion for forms up to 4 pages and forms will be completed in 5 business days. This does not include sports, school or camp physicals as long as the patient has been seen by the Doctor within one year. Please contact the office for pricing information for longer forms and letters.

No Show Policy

- ❖ Please notify the office within 24 hours of your appointment if you are not able to make an appointment. Missed (no-show) appointments are subject to a \$40 fee per missed appointment (not covered by insurance). Patients with more than 3 "no shows" will be discharged from the practice.

HIPAA RECEIPT OF INFORMATION

- ❖ I acknowledge I have received a copy of the Notice of Privacy Practices and that I can address questions, complaints and concerns to the practice administrator.
- ❖ I, the undersigned patient, hereby authorize Brookfield Primary Care, LLC and Robert Fitton, MD to use my medical information ("Individually Identifiable Health information) for treatment, payment and health care operations purposes.
- ❖ I have read, understand and agree to comply with all of the above policies.

Patient or Guardian Signature Date

Visit our Web site at www.drfitton.com. You can request appointments and renew prescriptions. Try it, it is informative and easy.

Effective Date: 1/1/2011

Brookfield Primary Care, LLC
Robert Fitton, MD

COVERED COMPONENTS OF THE HYBRID COVERED ENTITY

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE TELLS YOU HOW YOUR MEDICAL RECORD MAY BE USED AND SHARED AND HOW YOU MAY GET THIS INFORMATION.

PLEASE READ IT CAREFULLY.

OUR PLEDGE TO YOU

Your health information is something that the **BROOKFIELD PRIMARY CARE, LLC** has always worked to keep private. We also are ethically and legally bound to keep it confidential under state and federal laws.

WHAT IS THIS DOCUMENT?

This document, called a Notice of Privacy Practices, tells you how we may use and share your health information. This includes using and sharing it so that we may provide you with health care and be paid for it, and so that we may run our business and follow state and federal legal rules. We must follow the terms of this notice.

WHO FOLLOWS THIS NOTICE

This notice is for **BROOKFIELD PRIMARY CARE, LLC**. Other separate health-care providers at the U of L Medical Center also may provide you with health services. You might receive a notice of privacy practices from them, too. If you are seen in a hospital at the U of L Medical Center, it will give you a notice that covers medical information gathered during your visit there including the information created by **BROOKFIELD PRIMARY CARE, LLC**.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WITHOUT YOUR PERMISSION

Treatment. We will use and share your medical record for your care.

Example: Doctors, dentists, students, medical residents or other university workers may read your record to learn if a treatment is working. Your medical information also may be shared with doctors or dentists outside **BROOKFIELD PRIMARY CARE, LLC** to decide the best treatment for you.

Payment. We may use and share your medical information to be paid for the care and services we provided you.

Examples: We may contact your insurance company to learn if a service is covered. We may bill you or your insurance company for the services we provide.

Health-care Operations. We need to use and share your health information to run our health-care business. We may use or share your information for several reasons.

Examples: Our staff may use your medical information to make sure that you and other patients get the best possible care. Medical students may see the information as part of their training. Others on our staff may use it to make sure that billing is being done correctly. In certain special conditions, other health-care providers may get your information from us to run their businesses.

Business Associates. We may share your medical information with another company or organization, called a "business associate" that we hire to provide a service to us or on our behalf. We will only share your information if the business associate has agreed in writing to keep it private.

Example: A company that submits bills on our behalf to your insurance company.

Appointment Reminders. We may contact you to remind you of an appointment or to change one. We may also let you know that it is time for a follow-up appointment or a regular check-up.

Health-Related Benefits, Services and Treatment

Alternatives. We may tell you about interesting health-related benefits or services such as newsletters, announcements, possible treatments or alternatives.

Assistance for special projects, services and research.

BROOKFIELD PRIMARY CARE, LLC relies on the kindness of the community to help us provide quality health care to this region. *Patients who share their experiences and suggest ways to work with us are giving back in a meaningful way.* Their information also helps us improve and expand our services. We may use or share limited information, called demographic information, and the date you received care, to ask for your help. We also may share this information with our related foundation or business associates so they can contact you. Your generosity helps us continue to be an outstanding provider of health-care services in this region.

Required Disclosures. The Secretary of the Department of Health and Human Services may investigate privacy violations. If your health information is requested as part of an investigation, *we must share your information with the Secretary of the Department of Health and Human Services.* We will share your information if they ask for it as part of an investigation of a privacy violation. Under the same laws, we must give you information in your medical record. We are allowed to keep some information from you.

Required by Law. We must share medical information if federal, state or local law says so.

Public Health and Safety. We may share your medical information for public health reasons. These include:

- to prevent or control disease, injury or disability;

- to report births and deaths;
- to report child abuse or neglect;
- to report information to the FDA about the products it oversees;
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition; or
- to your employer in certain limited instances.

Abuse and Neglect. The law may require us to report suspected abuse, neglect or domestic violence to state and federal agencies. Your information may be shared with these agencies for this purpose. Generally, you will be told that we are sharing this information with these agencies.

Health Oversight Activities. Certain health agencies are in charge of overseeing health-care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Legal Proceedings. If a court or administrative authority orders us to do so, we may release your health records. We will only share the information required by the order. If we receive any other legal request, we may also release your health record. However, for other requests we will only release the information if we are told that you know about it, had a chance to object and did not.

Law Enforcement. We may share health information if a law enforcement official asks for it:

- to respond to a court order, warrant, summons or other similar process;
- to identify or locate a suspect, fugitive, material witness or missing person; or
- to obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:

- if we believe a death was the result of a crime;
- to report crimes on our property; or
- in an emergency.

Coroners, Medical Examiners and Funeral Directors. We may share health information with a coroner or medical examiner to identify a dead person or find the cause of death. We also may release health information to funeral directors if they need it to do their job.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.

Research. We may share your medical record with researchers, without your permission, in very limited situations. In most cases, a researcher must submit his/her request to see your information to a special group called the Institutional Review Board ("IRB"). This group will decide if it should allow the researcher to use or

share your information. Your medical information also may be used by or shared with researchers to prepare for research, but only under strict conditions. Under similar strict conditions, medical information about dead people can be used or shared.

To Prevent a Serious Threat to Safety. We may use and share your medical information to prevent a serious threat to your health and safety or the health and safety of others.

Special Governmental Functions. We may share your medical information with:

Authorized federal officials

- for intelligence, counter-intelligence and other national security activities authorized by law; or
- to protect the president.

Armed forces command authorities or the Department of Veteran's Affairs

- to see if you are fit for military duty or eligible for veterans health services; or
- to see if you are medically fit to receive a security clearance by the Department of State.

Correctional facility or law enforcement official or agency if you are an inmate or under the custody of a law enforcement official or agency, if necessary, to:

- help the correctional facility provide you with health care; or
- protect the health and safety of you and/or others.

Workers Compensation. We may share your health information with agencies or individuals to follow workers compensation laws or other similar programs.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WHEN WE HAVE GIVEN YOU A CHANCE TO OBJECT.

Individuals Involved in Your Care or Payment for Your Care. We may share medical information about you with your family members, friend or any other person you tell us who is involved in your medical care or who helps pay for it.

We may tell your family or friends your condition and that you are in one of our facilities. We also may share medical information about you to a disaster relief agency so that your family can be told of your condition and location.

Usually you will have a chance to object to the sharing of this information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information, described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to **BROOKFIELD**

PRIMARY CARE, LLC at the address given at the end of this notice.

Right to Request Special Communications. You have the right to ask us to contact you about medical matters in a certain way or at a certain place. We will follow all reasonable requests. Your request must tell us how you wish to be contacted.

Right to Inspect and Copy. You have the right to read or get a copy of your health information, with some exceptions. We may turn down your request under certain circumstances. If we do so, you may ask for a licensed health-care professional chosen by us to review why we turned you down. We will follow the reviewer's decision.

Right to Request Changes. If you believe the health information that we created is wrong or incomplete, you may ask us to change it. *You must provide a reason why you want the change.* We cannot take out or destroy any information already in your medical record. We also are not required to agree to make the change. If we do not agree to the change, you can write a letter about the changes. We will send you one back saying why we will not make the changes. You may then send another disagreeing with us. It will be attached to the information you wanted changed or corrected.

Right to an Accounting of Disclosures. We are required to track who we share your health information with under certain circumstances. You have the right to ask for a copy of this list. We do not have to track every time we share your health information with others. *Your request must give a time period, which may not be longer than 6 years and may not include dates before April 14, 2003.*

Right to Request Restrictions. You have the right to ask for a restriction or limitation on the medical information we use or share about you for payment, treatment or health-care operations and the information we may share with your family, friends or others involved in your care. We are not required to agree to your request. If we agree, we will follow your request unless the information is needed to provide you with emergency treatment. You must tell us the type of restriction you want and to whom it applies.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice will be posted and available at each location where medical services are provided and at www.drfitton.com

OTHER USES AND SHARING OF YOUR HEALTH INFORMATION

All other uses and sharing of your health information will be done only with your written permission.

CHANGES TO THIS NOTICE.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. Any changes in this notice will be posted on our Web site at www.drfitton.com. The revised notice also will be available at any of the locations where **BROOKFIELD PRIMARY CARE, LLC** offers services.

WHAT IF I HAVE QUESTIONS OR NEED TO REPORT A PROBLEM?

If you have any questions about this notice or about how your health information is used or shared by us please contact the **BROOKFIELD PRIMARY CARE, LLC**'s Privacy Officer **in writing to, 246 Federal Road, Unit C 31, Brookfield, CT 06804.**

If you believe your privacy rights have been violated, you may file a complaint with us.

To file a complaint, please contact (in writing) the Privacy Officer, **at Brookfield Primary Care, LLC, 246 Federal Road, Unit C 31, Brookfield, CT 06804.** Please give as much information as possible so that the complaint can be looked into properly.

You may also file a complaint with the Secretary of the Department of Health and Human Services.

Your care will not be affected if you file a complaint, nor will any action be taken against you.