Rehabilitation Associates of Indiana
PATIENT INFORMATION FORM

Today's Date_____ RAI Chart No. _____

Patient's Name: _____Date of Birth: _____
(Last) (First) (M.I)
Address: _____
(City) (State) (Zip)

Home Phone Number: (____) _____ Work Number: (____) _____ Cell: (____) _____
Email Address: _____
Social Security Number: _____Sex at Birth: Male/Female: _____ Decline to answer _____Age: _____
Patient's Employer: _____ Occupation: _____
Employer Phone Number: (_____) _____ Address: _____
Gender Identity Male _____Female_____ Transgender man/trans man/female-to-male (FTM)_____
Transgender women/trans woman/male-to-female (MTF)_____ Additional gender category (or other); please specify:_____ Decline to answer_____

Name of Spouse or Significant Other:_____ _____
Spouse's Employer: _____ Employer's Phone Number: (____)_____
If patient is a minor, Parent/Guardian Name(s): _____
Home Phone Number: (____) _____ Work Number: (____) _____ Cell: (____) _____

Primary Care Physician: _____Phone Number: (_____) _____
Address: _____
(City) (State) (Zip)

Referring Physician: _____ Phone Number: (_____) _____
Address: _____
(City) (State) (Zip)

Emergency Contact Name (not living with you): _____

Phone Number: (_____) _____ **Relationship:** _____

Responsible Party (If other than the patient, please complete):
Name _____ Relationship to Patient _____
Address, if other than same _____
Home Phone # (_____) _____ Work Phone # (_____) _____

Power of Attorney or Guardianship Name _____
Address, if other than same _____
Home Phone # (_____) _____ Work Phone # (_____) _____

ACCIDENT INFORMATION
Is this visit due to an auto accident? □ Yes □ No **Is this accident covered by auto insurance? □ Yes □ No**

If yes, adjuster / contact person: _____ Phone # (_____) _____
Name of Insurance Carrier: _____ Claim # _____
Date & Time of Accident: _____

Is this visit due to an injury at work? □ Yes □ No **Has a first report of injury been file by your employer? □Yes □No**
If yes, adjuster / contact person: _____ Phone # (_____) _____
Name of Employer of Work Comp Insurance _____ Phone # (_____) _____
Claim # _____ Date & Time of Accident _____

MEDICAL INFORMATION

PATIENT NAME: _____ Height _____ Weight_____
What part of the body is to be treated? _____ □ Right _____ □ Left _____
Date problem started/Date of Injury _____ Where did this happen? □ **Auto** □ **Work** □ **Other**

Drug Allergies (□ None) _____

Medications (Name & Dosage) Prescription & Nonprescription (□ I take **no** prescription medications)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List All Surgeries (Type of surgery & year) □ I have never had a surgery □ Complications

_____ _____ _____
_____ _____ _____
_____ _____ _____

Social History
Do you smoke? □ Yes □ No Per Day_____ Do you use an E-Cig or Vape □ Yes □ No
Do you consume Caffeine? □ Yes □ No Soda, Coffee, Tea (Amt per day_____ Amt per week_____)
Do you average 3 or more alcoholic beverages per day? □ Yes □ No (Amt per day_____ Amt per week _____)
Do you use recreational drugs? □ Yes □ No (circle): Cocaine, Marijuana, PCP, Methamphetamine, and/or _____
(Current use _____Past Use_____)
Highest Level of Education Completed_____

Family History
If any immediate family has had the following, please circle to Indicate Mother, Father OR Sibling (**not yourself**)

Epilepsy: M F S	Bleeding Disorder: M F S	Drug Addiction: MF S	Fibromyalgia: M F S
Migraine: M F S	Heart Disease: M F S	Cancer: M F S	Mental Illness: M F S
Glaucoma: M F S	Stroke: M F S	Osteoarthritis: M F S	**None of These in My Family**
Diabetes: M F S	Hypertension: M F S	Psoriasis/Psoriatic Arthritis: M F S	
Thyroid Disease: M F S	High Cholesterol: M F S	Rheumatoid Arthritis: M F S	
Anemia: M F S	Alcoholism: M F S	Systemic Lupus Erythematosus: M F S	
Asthma M F S			

Opioid Risk Tool

			Mark Each Box That Applies
1.	**(Family – Mother, Father, Sibling)** History of Substance **Abuse**	Alcohol	☐
		Illegal Drugs	☐
		Prescription Drugs	☐
2.	**(Personal)** History of Substance **Abuse**	Alcohol	☐
		Illegal Drugs	☐
		Prescription Drugs	☐
3.	**(Personal)** History of Preadolescent Sexual **Abuse**		☐
4.	**(Personal)** Psychological Disease	Attention Deficit Disorder	☐
		Obsessive Compulsive Disorder	☐
		Bipolar	☐
		Schizophrenia	☐
		Depression	☐
5.	**None of these apply to me**		☐

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

PAST MEDICAL HISTORY

☐ No Significant Past Medical History

Cardiovascular

☐ Angina
Aneurysm _____
☐ Atrial Fibrillation
☐ Carotid Artery Disease
☐ Blood Clot
☐ DVT
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Edema
☐ Heart attack
☐ Heart murmur
☐ Hyperlipidemia
☐ Hypertension
☐ Pacemaker
☐ Palpitation
☐ Peripheral Vascular Disease
☐ Phlebitis
☐ Rheumatic Fever

Pulmonary

☐ Allergic Rhinitis
☐ Asbestosis
☐ Asthma
☐ COPD
☐ Pneumonia
☐ Sinusitis, chronic
☐ Shortness of Breath
Sleep Apnea _____

Gastrointestinal

☐ Cirrhosis
☐ Diverticulitis
☐ Gastritis
☐ GERD
☐ Hemorrhoids
☐ Irritable Bowel Syndrome
☐ Peptic Ulcer Disease
☐ Rectal Bleeding
☐ Anorexia
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Abdominal hernia

Genitourinary/Renal

☐ BPH/Prostatitis
☐ Incontinence
☐ Pyelonephritis
☐ Dysuria
☐ Hematuria
☐ Kidney failure/dialysis
☐ Kidney Stones
Kidney disease _____

Infectious Disease

☐ AIDS/HIV
☐ Shingles
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Histoplasmosis
☐ Mononucleosis
☐ Lyme Disease
☐ Meningococcus
☐ Mumps
☐ Polio
☐ Post Herpetic Neuropathy
☐ Rubella
STDs _____
Tuberculosis/+PPD _____

Neurologic

☐ Alzheimer's Disease
☐ Bell's Palsy
☐ Cervical & Lumbar stenosis
Headaches _____
☐ Carpal Tunnel Syndrome
☐ Cerebral Palsy
☐ Cervical radiculopathy
☐ Convulsions/Fainting Spells
CVA/Stroke _____
☐ Neuropathy without Numbness/Tingling
☐ Neuropathy with Numbness
☐ Neuropathy with Tingling
Epilepsy/Seizure _____
☐ Dementia
☐ Gait disturbance
☐ Lumbar radiculopathy
☐ Lewy body dementia
☐ Multiple Sclerosis
☐ Myasthenia gravis
☐ Parkinson's Disease
☐ Pituitary Adenoma
☐ RLS
Spinal Stenosis_____
☐ Syncope
☐ Dystonia
☐ Torticollis
☐ Trigeminal neuralgia
☐ TIA
☐ Tremors
☐ Vertigo

HEENT

☐ Glaucoma
☐ Hearing Loss
☐ Macular Degeneration
Vision Loss _____

Hematology

☐ Anemia
☐ Bruising tendency
☐ Hemophilia

Endocrine & Metabolic

☐ DM Type I
☐ DM Type II
☐ Gout, Arthropathy
☐ Hypoglycemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Obesity, Morbid
☐ Vitamin B12 Deficiency
☐ Vitamin D Deficiency

Cancer

Specify _____

Rheumatology

☐ Ankylosing Spondylitis
☐ Chronic Fatigue Syndrome
Lupus _____
☐ Fibromyalgia
☐ Rheumatoid Arthritis
☐ CREST
☐ Sarcoidosis
☐ Polymyalgia Rheumatica
☐ Psoriatic Arthritis
☐ Raynaud's syndrome
☐ Scleroderma
☐ Polymyositis
☐ Vasculitis
☐ Dermatomyositis
☐ Crohn's Disease/Ulcerative Colitis
☐ Temporal Arteritis

Musculoskeletal

DDD _____
Neck/back pain _____
Fracture _____
☐ Osteoarthritis
☐ Sciatica
☐ Scoliosis
☐ Vertebral Compression Fracture
Amputations _____

Skin

☐ Eczema
☐ Psoriasis
☐ Rash without Lesion
☐ Rash with Lesion
Open Wounds _____

Psychiatry

☐ Alcoholism
☐ Anxiety/Panic Disorder
☐ Bipolar Disorder
☐ Depression
Drug Abuse_____
☐ Insomnia
☐ Schizophrenia
☐ Personality disorder
☐ Hallucinations
☐ Suicidal ideation

Other Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

THE ABOVE INFORMATION IS COMPLETE AND ACCURATE _____DATE_____

Patient's Signature

Reviewed by (for office use only) _____ Date _____

REHABILITATION ASSOCIATES OF INDIANA
Consent for Treatment
Please read carefully

The undersigned authorizes examination and treatment upon (print patient name) _____

By Rehabilitation Associates of Indiana, a medical corporation and its physician associates, Dr. Eric Aitken, Dr. Tammy Christenberry, Dr. Earl Craig, Dr. Steven Neucks, Dr. Shiva P. Gangadhar, Dr. Grenville Fernandes, Tara Riley, PA-C and/or employees, assistants, and designees.

I understand that such service is largely limited to Physical Medicine and Rehabilitation and Electrodiagnostic Studies, a medical specialty, I understand that my care by physicians of Rehabilitation Associates of Indiana is limited to Physical Medicine and Rehabilitation and that general medical care should be obtained by a physician practicing family practice medicine or pediatrics.

I understand that Physical Medicine and Rehabilitation Medicine, like other branches of medicine, is often an inexact science, and that no guarantees have been made to me concerning the results of any treatments rendered by Rehabilitation Associates of Indiana. I additionally understand that risks exist, and complications may occur with treatment, and these will be discussed with me in relation to my specific condition.

Signed _____Date _____

Witness _____

INSURANCE AND FINANCIAL RESPONSIBILITY

The undersigned authorizes Rehabilitation Associates of Indiana, its physicians, or employees to release any office or hospital medical records to, or prepare reports for, my insurance company of third party payor to pay directly to Rehabilitation Associates of Indiana any benefit for services rendered to (print name of patient) _____

I understand that the financial burden of payment, however, rests with me, the undersigned (patient or responsible party) regardless of the existence of third party reimbursement, insurance, or any lawsuit that may be pending.

I understand that payment for office visits are due at the time of service, and the payment for other associated services are due within 30 days of billing or insurance filing. I understand that if for any reason the account should become delinquent, I realize it could be turned over to a collection agency. I agree to reimburse RAI the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I understand that Rehabilitation Associates of Indiana will provide me with an estimate of its fees for expected services upon request.

Signed _____Date _____

Witness _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed _____ Date _____
Relationship (if not signed by the patient) _____

Internal Use Only
If patient/patient's representative refuses to sign and acknowledge, please document date and time notice was presented to patient and sign below.

Presented on (date and time) _____By (name and title) _____

REHABILITATION ASSOCIATES OF INDIANA
SPECIALIZING IN ADULT PHYSICAL MEDICINE AND REHABILITATION, INTERNAL MEDICINE, RHEUMATOLOGY AND ELECTRODIAGNOSTIC MEDICINE

Adult PM&R
Earl J. Craig, M.D.
Eric D. Aitken, M.D.
Shiva P. Gangadhar, M.D.
Grenville R-J. Fernandes, M.D.

Internal Medicine
Tammy L. Christenberry, M.D.

Rheumatology
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717 S. Rogers
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(812) 337-0714 – Fax

MEDICATION MANAGEMENT/ TREATMENT AGREEMENT

This Agreement between_____, ("Patient") and Rehabilitation Associates of Indiana ("Doctor") is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medications prescribed by the Doctor for the Patient: ***Please initial in each blank to acknowledge having read the agreement.***

_____I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

_____I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

_____I will not use any illegal controlled substances, including marijuana, cocaine, etc.

_____I will not share, sell or trade my medication for money, goods or services.

_____I will not attempt to get pain medication from any other health care provider. I understand that doing so will result in termination from the practice.

_____I understand it is against RAI's policies to consume alcohol while taking prescription pain medication. Doing so will result in termination from the practice.

_____I will notify RAI/my doctor immediately should I become pregnant while receiving pain medications. (**If applicable**)

_____I will notify RAI/my doctor immediately if my contact information changes. (Address and phone numbers)*

_____ I am aware that I may be randomly selected for a pill count and/or a Urine Drug Screen and must comply within the allotted time or be released from the practice.

If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure there is no duplication.

_____ **I will discontinue all previously used pain medications, unless told to continue them.**

_____ I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

My Pharmacy is_____ located at_____

Telephone number: _____

(We understand it may be necessary to change pharmacies due to the availability of your prescribed medications.)

____ I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Indiana Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

____ I authorize the Doctor to provide a copy of the Agreement to my pharmacy.

____ I agree that I will submit to a Drug screen (blood, urine or oral swab) when requested by my doctor to determine my compliance with this agreement and my regimen of pain control medications.

____ I understand there are risks when taking an opioid medication that includes but is not limited to the risk of opioid dependence, over sedation, slowed breathing, addiction and overdose. The risks are raised when using opioids without an abuse deterrent.

____ I agree that I will use my medication at the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time , may be cause to be discharged from the practice and **could possibly cause my death**.

____ I understand that this medication regimen will be reviewed periodically and the Physicians at Rehabilitation Associates of Indiana reserve the right to withdraw as my treating physician at any time. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

Doctor and Patient agree this this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medications by the Doctor and the termination of the Doctor/Patient relationship.

My goal for treatment is to:

_____

Examples: (Be pain free, Drug free, improve my functional capacity, improve my quality of life etc....)

This agreement is entered into on this _____ day of_____, _____.

Patient:_____ Doctor:_____

I acknowledge receipt of a copy of this agreement on the date stated above._____

Revised 8/20/21

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Office Policies

Patient Name: _____Date of Birth: _____

Thank you for choosing us to provide health care for your conditions. We appreciate your confidence and trust. Payment for your care is considered a part of your treatment program. If you have any questions regarding our financial policy, please call our billing department during regular office hours. The following is a statement of our policies that we require you to ***read, initial and sign prior to any treatment***. Your comfort and satisfaction is important to us. Please feel free to call to let us know your concerns so we may address them.

_____**Initial office forms**. All persons must complete the patient and insurance information sheets prior to being seen by the physician. If these forms are not completed, you may be asked to reschedule your appointment.

_____ **Insurance.** Our insurance claims are computerized to insure proper filing. We will automatically prepare and file insurance claims for the service you receive. However, please keep in mind that it is still the patient's responsibility to make sure the insurance company provides payment. It is not the responsibility of this office or the insurance company to finalize payment; it is the patient's responsibility. If you have chosen to see our Physicians as an "Out of Network" provider and you do NOT have a written referral, payment in full is expected at the time of service. We require all insurance deductibles/copays to be made at the time of service without exception. **You are obligated and responsible** to pay your portion. We accept payment by **cash, check, debit or credit card**.

_____**Co-payments** for insurance are due at the time of service. If you are not able to pay your co-pay on the day of service, we will assist you in rescheduling your appointment. If you do not have insurance, we expect payment in full at the time of service.

_____**Statement of Managed Care Responsibilities:** In order to accommodate the need and requests of patients, we have enrolled in a number of managed care programs. It is difficult to keep track of all the particular nuances of these plans and changes in these plans. Even within the same insurance company, the plans can be different. **Therefore it is your responsibility to inform us of any preauthorization requirements in your contract. If we subsequently treat you without the necessary authorization, we will bill you directly and you hereby accept full responsibility for these charges.**

_____**Lost Prescriptions and Prescription Refills:** Prescriptions refill requests are handled during office hours by phone from 9am to 3pm. **Refill requests may take 72 hours to process**. No opioid (pain pills) medications will be prescribed after the office closes for the day. You will be responsible to request refills within 3-4 days before the medication is due. No opioid (pain pills) medications will be prescribed before the normal due date. This includes lost or stolen medications, lost or stolen written prescriptions, or taking more medication than prescribed. If you fail to keep a scheduled appointment, the medications may not be refilled until you are seen again in the office. Please note that prescription refill requests as well as any other issues you call the office for will be handled in the order received. Please refrain from calling the office multiple times for the same issue as this only delays our response time.
Opioid (pain pills) refills are sent to the pharmacy electronically. If you receive a prescription for opioid (pain pills) medication from a physician at Rehabilitation Associates, you commit to only receiving opioid medications from this physician and no other physician. You will commit to obtaining your opioid (pain pills) prescriptions from one pharmacy. Please note: we no longer write prescriptions for benzodiazepine medications.

_____**On-Call:** Rehabilitation Associates has a physician on-call 24 hours a day to address emergencies. **These physicians are available for phone consultations for emergencies only**.
An after- hours phone call to the on call physician for a non emergent problem may incur a fee. This fee is typically not reimbursed by insurance. You will be directly responsible for this fee.

_____**Medicare:** Our office has enrolled in the Medicare program, which means we have a contract with CMS to accept Medicare assignment: We will complete and submit your Medicare insurance form for you. Medicare will pay its share of the bill directly to our office. You will be responsible for annual deductibles and co-payments. This office will request an *Advance Beneficiary Notice* for all procedures that Medicare may consider to be not medically necessary.

_____**Late arrival, late cancellation or "No Show":** We require 24 hours notice if you need to cancel an appointment. We often have a waiting list for patients to be seen. In order for our physicians to deliver quality care, you will need to arrive prior to your scheduled time to fill out paperwork. The physicians attempt to see patients on time. If the waiting time for the physician is too long, you may ask our staff to reschedule your appointment. Failure to keep an appointment, late arrival, or failure to provide 24 hour advance notice of cancelling the appointment, may result in a fee charged. Furthermore, if there are 2 or more missed appointments without advance notice, our professional relationship with you may be terminated and you will be asked to seek treatment from another health care provider. In the event of severe weather, please call the office to determine if the office is open or there is a delay in the scheduling.

_____**Medical Records Copying and Form Completion:** Requests for copies of medical records will be subject to a fee of .03 per page when they exceed 80 pages.
There will be a charge to complete forms for school, insurance forms, FMLA forms, credit forms, disability forms, and Return to Work/Restrictions forms.

_____**Treatment of Minors:** The parent or legal guardian who brings a minor to the office for medical care will be responsible for all medical bills incurred at the time of service.

_____**Workers Compensation:** We require 24 hours notice to cancel or reschedule an appointment. You may not cancel or reschedule an appointment without your workers compensation case manager or adjuster calling our office to authorize a change of appointment. Failure to obtain this notice and/or failure to keep your appointment will result in the possible determination of "noncompliance". This could result in your release from medical care and place you at Maximal Medical Improvement (MMI).

_____**Agreement to Financial and Office Policies:** I have read and completely understand the financial policies stated above and I agree to accept full responsibility as described above. I hereby agree to pay Rehabilitation Associates of Indiana, PC for the charges of all medical services provided. In case of default of payment of fees or being classified as a delinquent account, I understand RAI may send the debt to a collection agency, and all costs, and expenses, including reasonable attorneys' fees incurred in such collection efforts are the responsibility of the losing party. If I am agreeing and signing on behalf of a minor, I affirm that I have the legal right to consent and agree on behalf of that minor.

Signature: _____Date_____

Rehabilitation Associates of Indiana

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Policy on Medical Record Privacy

This Notice describes the way our practice will treat medical records and other health information that we have regarding your medical care. We are required to keep records for each of our patients in order to keep a record of your care, including your diagnosis, treatment, services you receive, and other information. We are required by law to protect your personal medical record by keeping it private and following certain rules that dictate whether and when we can use or disclose your information.

This Notice informs you of the ways we may use and disclose your health information. It also notifies you of your rights and our obligations in our use and disclosure of your health information.

The law requires us to keep your health information private. We are also required to give you this Notice. You have the right to request additional copies of this Notice at any time by contacting the Privacy Officer identified below.

We reserve the right to change the Notice. We reserve the right to apply those changes to health information we currently have, as well as information we may receive in the future. If we change this Notice, you may request a new copy of the Notice at any time by contacting the Privacy Officer identified below. We will also keep a current copy of the Notice on display in our office. We are required to follow the terms of the Notice that is currently in effect.

How we may Use and disclose your health information.

We may use and disclose your health information for a number of purposes in connection with your medical care and in running our practice. The following lists a number of typical uses and disclosures within our practice, with explanations to help you understand your rights. You will not be asked to separately authorize us to do these things.

1. **Treatment**
   We may use your health information to provide you with medical treatment. For example, we may use your health information to diagnose your illness of injury, provide you with services, or refer you to another physician. We may disclose your health information to doctors, nurses, technicians, medical students, or other personnel who are involved in your care. We may also disclose your health information to people outside of our medical practice who may be involved in your medical care, such as family members, clergy or others.
2. **Payment**
   We may use and disclose your health information to your health plan, insurance company, HMO, or other third party in order to bill and collect for services provided to you. For example, we may give your health plan information regarding your diagnosis and treatment in order to be paid for your office visits, procedures, x-rays, or laboratory work. We may also provide information to determine whether your health plan pays for the medical care you need, and whether we need to get authorization from the health plan before treating you.
3. **Health Care Operations**
   We may use and disclose your health information in the process of running our medical practice. For example, we may use or disclose your information if we conduct quality assessment and improvement activities to ensure that our patients receive top quality medical care. We may also use or disclose your information in training and evaluation of our physicians and other staff, or as part of a medical review, audit, or legal activities.
4. **Appointment Reminders**
   We may use and disclose your health information to contact you as a reminder that you have an appointment with our practice.
5. **Treatment Alternatives**
   We may use and disclose your health information to tell you about or recommend treatment alternatives or health-related benefits and services that may be of interest to you
6. **Fundraising**
   We may use and disclose your health information to contact you to raise funds on behalf of our medical practice or on behalf of a charitable foundation that is related to us.
7. **Individuals Involved in your care or payment for your care.**
   We may disclose your health information to a family member of friend who is involved in your medical care, or who helps pay for your care. We may also tell your family or friends about your condition, for example, if you are admitted to the hospital. In addition, we may disclose your health information in the event of a disaster relief effort, so that your family can be notified about your condition, status and location.
8. **Required by Law**
   We will disclose your health information when we are required to do so by federal, state or local law.
9. **Public Health Risks**
   We may disclose your health information for public health activities, such as reporting disease, injury or disability; births and deaths; child abuse or neglect; defects, recalls, or problems with drugs, medical devices, or other products; to prevent or control disease, injury or disability; exposure to or risk for diseases or conditions. We may also notify authorities if we believe you have been the victim of abuse, neglect or domestic violence, if we are required or permitted by law to do so, or if you agree to the notification.
10. **Health Oversight Activities**
    We may disclose health information to a health oversight agency authorized by law for audits, investigations, inspections, and licensure. Health oversight agencies generally oversee the health care system, government health programs (such as Medicare and Medicaid), and the enforcement of civil rights laws.
11. **Judicial and Administrative Proceedings**
    We may disclose your health information in response to a court order or administrative order. We may also disclose your health information to respond to a subpoena, discovery request, or other request that is not issued by a judge or administrator, but only if efforts have been made to inform you of the request or to get a protective order for the information.
12. **Law Enforcement**
    We may release health information if asked to do so by a law enforcement official under the following circumstances:
    - If you have incurred certain injuries or wounds that are legally required to be reported;
    - In response to a court order, subpoena, warrant, summons, investigative demand, or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime if under certain limited circumstances;
    - About a suspicious death that we believe may be the result of criminal conduct;
    - About criminal conduct on out premises; and
    - In emergency circumstances to report a crime, its location, or information about the person who may have committed the crime.
13. **Coroners, Medical Examiners, and Funeral Directors**
    We may disclose your health information to a coroner or medical examiner. This may be necessary, for example to identify or determine the cause of death of a deceased person, or as otherwise required by law. We may also disclose health information to funeral directors as necessary to carry out their duties.
14. **Organ and Tissue Donation**
    We may use or disclose your health information to organizations that handle organ procurement to facilitate organ or tissue donation and transplantation.

15. **To Avert a Serious Threat to Health or Safety**

    We may use and disclose your health information when necessary to prevent or lessen a serious threat to the health and safety of you, the public, or another person. Any disclosure would be made to law enforcement or someone else who can help prevent or lessen the threat.

16. **Research**

    We may use and disclose your health information when necessary to prevent or lessen a serious threat to the health and safety of you, the public, or another person. Any disclosure would be made to law enforcement or someone else who can help prevent or lessen the threat.

17. **Specialized Government Functions**

    We may use or disclose your health information for military command authorities, upon your separation or discharge from military service, to authorized officials. We may also disclose your health information to the appropriate government officials when it is necessary to conduct intelligence or other national security activities authorized by federal law. In addition, we may release your health information if it relates to protection of the President of the United Sates of foreign heads of state. Finally, we may disclose certain information related to members of the armed services and foreign military services to the appropriate personnel.

18. **Inmates**

    If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure the safety of the correctional facility.

19. **Workers' Compensation**

    We may disclose your health information in relation to workers' compensation or similar program established by law that provides benefits for work-related illness or injuries.

    We may also disclose your health information to your employer if the health care services we provide to you are at the request of your employer in order to carry out work-place medical surveillance, but only if we notify you first.

Your Rights Regarding Your Health Information

1. **Your Right to Restrict our Activities**

   You have the right to request that we restrict the use or disclosure of your health information for treatment, payment, or healthcare operations (as described above). You may also restrict us from disclosing your health information to family members or friends. For example, you may request that we limit what information we provide to your family members regarding medication you may be taking.

   We are not required to agree to your request. If we agree to your restrictions or limitations, we will comply with your wishes unless the information is needed to provide emergency treatment to you. To request restrictions or limitations, you must make a written request to the Privacy Officer identified below. In your written request, you must tell us (1) what information you want to limit; (2) whether you want to limit use of the information and/or disclosure of the information; and (3) to whom the limitations or restrictions will apply (for example, disclosures to your spouse).

2. **Your Right to Request Confidential Communications**

   You have the right to tell us how you would like us to communicate with you. For example, you may ask that we call you at a certain phone number, or you may tell us whether we may leave message for you.

   To request confidential communications, you must make your request in writing to the Privacy Officer listed below. Your request must specify how or where you wish to be contacted. We will follow all reasonable requests for confidential communications.

3. **Your right to Inspect and Copy**

   You have the right to inspect and copy your health information, including most of your medical and billing records. You do not have the right to review any psychotherapy notes, information created for use in legal actions, or other information covered by certain laws.

   If you would like to inspect and/or copy your health information, you must submit your request in writing to the Privacy Officer listed below. If you request a copy of the information, we may charge you a reasonable fee for copying, postage, or other expenses related to your request.

   We may deny your request to inspect and/or copy your health information. If we do, you may request that the denial be reviewed. We will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

4. **Your Right to Amend**

   If you feel that your health information is incorrect or incomplete, you may ask us to amend your records. To request an amendment, you must submit a written request to the Privacy Officer identified below. Your request must state the reason you believe an amendment is necessary.

   We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if: (a) we did not create the information (unless the entity that created the information is no longer available); the information is not in our possession or control; (c) you would not be permitted to inspect or copy the information; or (d) the information is accurate and complete.

5. **Your Right to an Accounting of disclosures**

   You have the right to request an "accounting of disclosures". This is a list of certain disclosures of your health information that we have made.

   To request this list of disclosures, you must submit a written request to the Privacy Officer identified below. Your request must state a time period for which the accounting is requested. This time period may not be longer than six years and may not include dates before April 14, 2003. You will receive one list per year without charge. We may charge you for the costs of providing additional lists within one year after your first request. We will notify you of the cost involved and you may choose to withdraw or modify your request if you do not wish to pay the cost.

6. **Your right to Receive a Paper Copy of this Notice**

   If you are receiving this notice electronically, you have the right to request a paper copy of this notice by making a request to the Privacy Officer identified below.

Changes to this Notice

We reserve the right to change this notice, and to apply the revisions or changes notice to health information we already have about you, in addition to information we create or receive in the future.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer identified below, or you may contact Health Care compliance Group, LLC. You may also file a complaint with the United States Secretary of the Department of Health and Human Services. To file a complaint with our medical practice, you may contact the Privacy Officer at the phone number or address listed below to file a written complaint, or you may contact Health Care Compliance Group, LLC @ 800-816-1161. We encourage your feedback regarding our privacy policies, and we will not retaliate against you in any way if you file a complaint.

Other Uses of Your Health Information

This notice only describes the ways we may use and disclose your health information without obtaining further permission from you. There may be other reasons we may request to use or disclose your health information. If we need to do so, we are required to get your written authorization. If you grant us this further authorization, you may revoke it at any time by giving us written notice that you no longer authorize us to use or disclose your health information for those purposes. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Contact Information

For questions regarding this notice, or to receive further information, please contact the Privacy Officer at

Rehabilitation Associates of Indiana
Phone 317-588-7130
Fax 317-588-7133
6330 E. 75th ST.
Suite 110
Indianapolis, IN 46250