Physicians CareConnection

FOR OFFICE USE ONLY
Initials _____
Reason_____

PLEASE PRINT CLEARLY

Physicians CareConnection Application

Name of Client_____
(Last) (First) (Middle Initial)

Date of Birth_____ **Gender:** ☐ Male ☐ Female ☐ Transgender M-F ☐ Transgender F-M

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Homosexual ☐ Questioning ☐ Other_____

Marital Status: ☐ Married ☐ Divorced ☐Single ☐ Widowed **Social Security Number (optional)** _____

If married, does your spouse live in the home with you? ☐ Yes ☐ No

Street: _____ **Apt/Lot #**_____

City:_____ **Zip:** _____ **County:** ☐**Franklin** ☐**Other** _____

I authorize Physicians CareConnection to send me text, email and voice messages. *This includes (but is not limited to) treatment- or care-related reminders and health education information.* ☐Yes ☐No

Telephone Number (Home): _____ **Cell Phone/Alt:** _____

Email:_____

Emergency Contact _____
(Name) (Relationship) (Phone)

Residency status? ☐ US Citizen ☐ Permanent Resident ☐ Visitor ☐ Student Visa

Employed: (Please select one only)
☐Full Time ☐Part Time ☐Unemployed ☐Disabled ☐Self Employed ☐Visiting ☐Seasonal ☐Retired ☐Student

Employer (if applicable) _____ **Source of Income if not employed** _____

Ethnicity (please check one) ☐Hispanic/Latino ☐Non-Hispanic/Latino
Race (choose all that apply)

__African
__African-American (Black)
__African-Somalian
__American Indian /Alaska Native
__Asian
__Asian Indian
__Caucasian (White)
__Chinese
__Filipino
__Guamanian / Chamorro
__Hispanic/Latino
__Japanese
__Korean
__ Multiple Races
__Native Hawaiian
__Russian/ former Soviet Union
__Samoan
__Spanish
__Vietnamese
__Other_____

When visiting a physician, do you need help speaking and understanding English? ☐Yes ☐ No

Is English your first language? ☐Yes ☐No **If no, please tell us what your first language is** _____

Transportation: ☐ Has transportation ☐ Needs Bus Pass ☐ Needs Gas Asst. ☐ Occasionally needs transport ☐ None

Please answer <u>all</u> questions by placing an [x] in <u>one</u> box next to the correct answer. Questions not answered may delay your application review process.

1. Do you currently have any health insurance? ☐ Yes ☐ No
If yes, please indicate which one:
☐ Medicaid ☐ Medicare ☐ VA Benefits ☐ Private Health Insurance

2. Have you ever served in the United States Military? ☐Yes ☐ No
(a.) Are you an active duty veteran? ☐Yes ☐No

3. Do you have a work related injury or do you have an open workers compensation case? ☐Yes ☐No
If yes, what is the injury? _____

4. Do you have any legal action anticipated regarding any injury or illness? ☐Yes ☐No

5. Are you the legal guardian or parent of any children under the age of 18 living in the home with you? ☐Yes ☐No
5a. If yes, how many?____what is their relation to you? _____

6. If you are a female**,** are you pregnant? ☐Yes ☐No

7. Are you having problems with your vision? ☐Yes ☐No

8. If you have diabetes or high blood pressure, was your last eye exam over a year ago? ☐Yes ☐No

9. What is your monthly gross household income? $_____/month
(a) Please identify your source of income: _____

Household includes you, your spouse, and children only. Income includes any earned or unearned money from each person in your household from any source, such as wages, self-employment, social security(SSDI), supplemental security income(SSI), food stamps, VA pension, workers compensation, alimony or child support.

***** If you have previously applied for the <u>Health Insurance Marketplace</u>, <u>Medicaid</u>, <u>VA Benefits</u>, or <u>Medicare</u> and were denied, please send a copy of the denial letter with this application.***

10. In the past 12 months, how many times have you been a patient in a Hospital Emergency Room? _____

11. In the past 12 months, have you had one person or place you think of as your personal doctor or health care provider?
☐Yes ☐No if yes, where _____

12. In the past 12 months, how easy/hard was it to get the health care you needed?

☐Very hard ☐Somewhat hard ☐Somewhat easy ☐Very easy ☐Did not need care in the past 12 months

13. Overall, how would you rate your health during the **<u>past 4 weeks?</u>**
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor

14. During the **<u>past 4 weeks</u>**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

☐Not at all ☐Very little ☐Somewhat ☐Quite a lot ☐Could not do physical activities

→→→→ CONTINUE TO NEXT PAGE →→→→

15. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your health?

□None at all □A little bit □Some □Quite a lot □Could not do daily work

16. How much bodily pain have you had during the **past 4 weeks**?

□None □Very mild □Mild □Moderate □Severe □Very Severe

17. During the **past 4 weeks**, how much energy did you have?

□Very Much □Quite a lot □Some □A little □None

18. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

□Not at all □Very little □Somewhat □Quite a lot □Could not do social activities

19. During the **past 4 weeks**, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?

□Not at all □Slightly □Moderately □Quite a lot □Extremely

20. During **the past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?

□Not at all □Very little □Somewhat □Quite a lot □Could not do daily activities

21. Compared to one year ago, how would you rate your health in general now?

□Much better than one year ago
□Somewhat better now than a year ago
□About the same as a year ago
□Somewhat worse now than a year ago
□Much worse now than a year ago

22. Where did you hear about the Physicians CareConnection? _____

23. **Education Level: (Please select the one that best describes the highest grade level achieved)**
□ College Graduate □ High School Graduate or GED □ Junior High (6-9) □ Toddler (not in school yet)
□ College Some □ High School Incomplete □ Elementary (K-5) □ No Formal Education
□ Technical School □ Junior College □ Post Graduate

24. **Are you currently in school or vocational training?** □ Yes □ No
If yes, what type of educational or vocational training programs are you completing?
□ Full time graduate □ High School □ Junior High (6-9) □ Part time undergraduate
□ Part time graduate □ GED □ Continuing Education □ Full time undergraduate
□ Technical School □ Junior College □ Post Graduate □ Other _____

25. **Are you interested in getting your GED?** □ Yes □ No

26. **Housing (Other Information)**: (Please select one only)
□ Own House □ Rent □ Live with Friends/Family □ Temporary (Shelter)□ Program Housing □ Homeless

27. **Do you feel that your home is a safe place for everyone that lives there?** □ Yes □ No **If no, why not?**
□ Environmental Reasons □ Overcrowded □ Structural Problems □ Pets □ Other _____

Please check the 'Yes' or 'No' box for EACH question. Check the boxes in the questions asked if applicable.

<table>
<tr><th>Yes</th><th>No</th><th>Question</th></tr>
<tr><td>□</td><td>□</td><td>Do you need help with child care?</td></tr>
<tr><td>□</td><td>□</td><td>Do you have any problems providing?
□ Housing □ Food □ Clothing □ Utilities □ Other _____</td></tr>
<tr><td>□</td><td>□</td><td>Do you have any legal issues that need to be resolved?
□ Children □ Collections □ Criminal □ Divorce □ Immigration
□ Landlord-Tenant □ Traffic Violation □ Other _____</td></tr>
<tr><td>□</td><td>□</td><td>Have you been in prison or jail? If yes, has it been within the past 12 months? □ Yes □ No</td></tr>
<tr><td>□</td><td>□</td><td>Are you currently on probation or parole? Probation/Parole Office Name _____</td></tr>
<tr><td>□</td><td>□</td><td>Have you been involved with Children/Adult Protective Services?
If yes, do you have an active case? □ Yes □ No Caseworker _____</td></tr>
<tr><td>□</td><td>□</td><td>Are you on Supplemental Social Security (SSI)?</td></tr>
<tr><td>□</td><td>□</td><td>Have you had a family crisis in the past year? If yes, what was the crisis?
□ Death □ Major physical illness □ Major behavioral health illness □ Major accident □ Prison/jail
□ Loss of home □ Financial difficulties □ Loss of relationship □ Substance abuse issue □ Other _____</td></tr>
<tr><td>□</td><td>□</td><td>Do you need a Dentist?</td></tr>
<tr><td>□</td><td>□</td><td>Do you have any oral health issues?
□ Difficulty eating/chewing □ Pain □ Oral Bleeding □ Skip Meals due to pain
□ Problem with dentures □ Lose teeth □ No teeth □ Other _____</td></tr>
<tr><td>□</td><td>□</td><td>Have you missed any scheduled health care appointments in the past 12 months?</td></tr>
<tr><td>□</td><td>□</td><td>Have you been admitted to the hospital in the past 12 months? If yes, where and when? _____</td></tr>
<tr><td>□</td><td>□</td><td>Diagnosed with mental health condition? □ADHD □Anxiety □Bipolar □Depression □Schizophrenia</td></tr>
<tr><td>□</td><td>□</td><td>Do you have allergies? (food, medication, environment)
Type of reaction (s): _____</td></tr>
<tr><td>□</td><td>□</td><td><u>MEDICATIONS:</u> List all medications currently being taken (for physical and/or emotional reasons) or discontinued within the last month (30 days). Include birth control pills and over-the-counter medications.
<table>
<tr><th>NAME OF MEDICATION</th><th>DOSAGE</th><th>HOW OFTEN TAKEN?</th><th>DOCTOR/CLINIC PRESCRIBING</th><th>HOW LONG TAKEN?</th></tr>
<tr><td>1</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2</td><td></td><td></td><td></td><td></td></tr>
<tr><td>3</td><td></td><td></td><td></td><td></td></tr>
<tr><td>4</td><td></td><td></td><td></td><td></td></tr>
<tr><td>5</td><td></td><td></td><td></td><td></td></tr>
<tr><td>6</td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>□</td><td>□</td><td>Have you had a flu shot?</td></tr>
<tr><td>□</td><td>□</td><td><u>Medical History (Patient History):</u>
Please check if you have ever been diagnosed with one or more of these conditions (check all that apply):
□ Allergies □ Bowel Disease □ Gout □ Migraines
□ Anemia □ Depression/Anxiety □ Hyperlipidemia □ Osteoporosis
□ Anticoagulation □ Diabetes □ Hypertension □ Obesity
□ Arthritis □ Diarrhea □ Kidney Disease □ Thyroid
□ Asthma/COPD □ Eye Disease □ Liver Disease □ Transfusions
□ Bleeding Tendency □ Epilepsy □ Major Blood Vessel Disease □ Stroke
□ Blood/Plasma □ GERD □ Multiple Sclerosis or Nerve Disease (e.g. Parkinson's)</td></tr>
<tr><td>□</td><td>□</td><td><u>Use of Tobacco Products (Social History):</u>
□Never □ Moderate □Rarely □ Heavy □ Quit (date)___ /___/____ Years _____ Packs per day_____</td></tr>
<tr><td>□</td><td>□</td><td><u>Use of Alcohol (Social History):</u>
□Never □ Moderate □Rarely □ Heavy</td></tr>
<tr><td>□</td><td>□</td><td><u>Use of Drugs (Social History):</u>
□Never □ Moderate □Rarely □Heavy Substance(s):_____</td></tr>
<tr><td>□</td><td>□</td><td>Is there a gun in the home? If so, is the gun locked? □ Yes □ No</td></tr>
</table>

CONSENT FOR TREATMENT AND HEALTHEXCHANGE

I hereby consent to the provision of diagnosis, care, and/or treatment by the Physicians CareConnection, and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of diagnosis, care, and/or treatment and am not subject to duress or under undue influence.

I hereby acknowledge that under §2305.234 of the Ohio Revised Code, subject to certain exceptions, the Physicians CareConnection and its health care professionals and health care workers who are volunteers are not liable in damages of injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteers, unless the action or omission constitute willful or wanton misconduct. I understand and hereby acknowledge that the Physicians CareConnection will provide me a copy of §2305.234 of the Ohio Revised Code, if I so request.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. With this Authorization, you agree that we, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Physicians CareConnection OR Isi Ikharebha.

Print Patient Name or Person Authorized to Consent* **Signature of Patient Name or Person Authorized to Consent***

Relationship, if not Patient **Date**

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF INFORMATION

I hereby request and authorize the use and disclosure of any and all information obtained through Physicians CareConnection (including but not limited to protected health information and records of substance abuse (including alcohol/drug abuse), mental health/illness and HIV related information (including AIDS testing) to Central Ohio HUB (and its network of care coordination agencies and healthcare providers, including Healthcare Collaborative of Greater Columbus, Hospital Council of Northwest Ohio, The Ohio Department of Health, and Medicaid Managed Care Plans (CareSource, Molina, United Healthcare Community Plan, Paramount, and Buckeye)), OSU Wexner Medical Center, CompDrug and the Healthy Beginnings at Home (HBAH) program, including Celebrate One, Columbus Metropolitan Housing Authority, Homeless Families Foundation and The SMRT Columbus Rides for Pregnant Mothers program.

The information may be communicated in writing and verbally.

I understand that the disclosure of this protected health information with the entities listed on this form is to help my care team share general information about my family's needs and services I utilize as it pertains to my care plan. I understand the care team will only disclose information that is necessary to provide me with integrative care coordination. This information will be collected and stored on the databases of the entities listed above.

This authorization will expire 2 year(s) from the date of my signature below. I understand that I may shorten, extend or revoke this authorization at any time by notifying:

Physicians CareConnection
Attn: Privacy Officer
1390 Dublin Road
Columbus, Ohio 43215

This authorization and request is fully understood and is made voluntarily on my part. I understand that information disclosed as related to this authorization may be subject to re-disclosure by the recipient of the information. I release Physicians CareConnection, its employees, agents and representatives of any legal liability that may arise from the release of information.

Print Patient Name or Person Authorized to Consent* **Signature of Patient or Person Authorized to Consent***

Relationship, if not Patient **Date**

Physicians CareConnection

Client Agreement

Program Overview

The Physicians CareConnection (PCC) doctors, area clinics, pharmacists, hospitals and many others are providing their services to help you get well and stay well. Through the Physicians CareConnection, we will help you to set up a medical home. A medical home is a place for you to receive continuous medical care. Most services are at no cost to you and some services will be provided based on your income.

General

You agree that you will:

1. Inform PCC of appointments with any doctor, clinic, or hospital other than the appointments scheduled by PCC.
2. Follow your treatment plan, for example: get prescribed medicines and take them as directed.
3. Promptly supply any information, which may be requested by PCC.
4. Subject to situations where a specific authorization is required by law, relevant information regarding your participation in this Network may be shared with other individuals, organizations and agencies solely at the discretion of PCC.
5. Immediately contact PCC if your income changes or if you become covered by Medicare, Medicaid, private insurance, or other health insurance or medical benefits.
6. Apply for Medicaid or other assistance programs at our request.
7. Contact PCC immediately with any changes in your address or phone number.
8. All children under 18 years of age must be accompanied by a parent or guardian to all appointments.

Appointments

You agree to:

1. Keep each physician's appointment. (If you miss two appointments without letting PCC know at least 24 hours before your appointment, you can be dropped from the Program).
2. Fill out all forms given to you during your medical appointment.
3. Fill out Hospital Care Assurance Program forms if you need to go to the hospital for any services.
4. Present your PCC ID card each time you see a physician or healthcare provider.
5. Call PCC to schedule your medical appointments.
6. Call PCC if a physician or healthcare provider schedules any follow up appointments for you.

Billing Assistance

You understand that:

- If you receive a bill (for any medical appointment that you had with one of ***our*** specialist ***only***) send it to the Physicians CareConnection office, so that we may be able to resolve them as quickly as possible.
- It is important that you fill out a Hospital Care Assurance Program form when receiving services from the hospital and cooperate in providing all necessary information required in completing those forms and updating information on these forms as needed.

Medication Assistance

You understand that:

- It is very important you receive and take your medications as prescribed.
- PCC will assist you in obtaining your medications for a nominal co-payment per monthly prescription for approved medications only.

Transportation Assistance

- PCC will assist you in providing transportation services when needed.
- Transportation services are to be used for PCC related appointments only.
- Abuse of transportation services may result in loss of transportation privileges.

In order to enable PCC to create a suitable environment for you to receive quality care, there are some guidelines which must be followed: Emergency room visits not covered. The Physicians CareConnection program does not cover emergency room expenses, ambulance or medical supply services. Please note that this Program is not a government program or an "entitlement." This Program, and your participation in it, is subject to termination at any time and for any reason. Your responsibilities to this Program, the assistance available and other conditions of the program may change at any time. We reserve the right to check what you have told us and to require that you pay for any assistance you may have received based on inaccurate information provided by you. PCC reserves the right to modify or terminate this agreement at any time.

By signing below, you confirm that you understand and agree to the above conditions.

Client Signature_____ Date _____

If you have questions call:

Physicians CareConnection at 614-884-2441

Rev 03/19

Please return completed application to The Physicians CareConnection 1390 Dublin Rd., Columbus, OH 43215

READ AND KEEP THESE PAGES FOR YOUR RECORDS

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Physicians CareConnection at 614-884-2441

Rev 03/19

THE PHYSICIANS CARECONNECTION

NOTICE OF PRIVACY PRACTICES

If you have any questions about this notice, you may contact the Privacy Official at, (614)-884-2441.

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.

This Notice will tell you about the ways in which Physicians CareConnection, Inc. ("PCC") may use and disclose medical information about you. It also describes your rights and certain obligations that we have regarding the use and disclosure of your medical information.

PCC is required by law to maintain the privacy of your health information, give you notice of our privacy practices with respect to your medical information, and follow the terms of this Notice. This Notice applies to all of the records of your care generated and maintained by PCC. PCC will share your medical information as necessary internally in order to carry out your treatment, obtain or provide payment for the services provided to you or operate PCC.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that PCC may use and disclose your medical information. These are examples and, therefore, not every permitted use and disclosure is listed.

For Treatment. PCC may use medical information about you to enroll you in PCC's Network so that medical treatment or services may be provided to you. We may disclose medical information about you to doctors, nurses, technicians, medical students and other trainees, or other PCC personnel who are involved in taking care of you. Different PCC personnel may share medical information about you in order to schedule appointments and coordinate the different services you need, such as prescriptions, lab work and x-rays. We may also disclose medical information about you to people outside PCC who may be involved in your medical care, such as physicians involved in your care, or other health care related entities such as hospitals or skilled nursing care facilities with whom you seek treatment.

For Payment. PCC may use and disclose medical information about you so that the treatment and services you receive may be paid by PCC, when applicable. For example, we may disclose your medical information to other health care providers, such as pharmacies, so that they can bill PCC for the health care services that they provided to you.

For Health Care Operations. PCC may use and disclose medical information about you for its operations. These uses and disclosures are necessary to run PCC and make sure that individuals enrolled in PCC's Network receive quality health care. For example, we may use medical information to review the treatment and services provided to you and to evaluate the performance of physicians participating in the Network that care for you. We may also disclose medical information to doctors, nurses, technicians, medical and nursing students, and other PCC personnel for review and learning purposes. We may also provide medical information to other health care providers who have a relationship with you and need the information for their own health care operations.

Appointment Reminders. We may use and disclose your medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved With or Concerned About Your Care. Unless you object, we may release information about your condition to a friend or family client relevant to his/her involvement in your care or payment for your care. There may also be instances where, because you are either not present or lack the capacity to object, we may release information about your condition to a friend or family client if we determine, based upon our professional judgment, that the release of information is in your best interests. We may also disclose your location and condition to assist or notify a family client or personal representative who is involved in your care. We may also disclose your information in a disaster relief effort so that your family can be notified about your condition and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. Often, you will need to give permission before we share your information with others for use in research. If your information is used, the researcher must keep your information safe and confidential. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with individuals' need for privacy of their medical information.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, Ohio law requires us to report gunshot and stabbed wounds as well as certain burn injuries.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation. We may release medical information about you for worker's compensation or similar programs which provide benefits for work-related injuries or illness.

Public Health Activities. We may disclose medical information about you for public health activities such as the prevention or control of disease, injury or disability; reporting of births and deaths; reporting of child abuse or neglect; and, reporting of reactions to medications or problems with products and to fulfill requirements of the U.S. Food and Drug Administration.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities allowed by law such as audits, investigations, inspections and licensure or disciplinary actions. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a Court Order, Administrative Order and certain subpoenas.

Law Enforcement. We may release medical information to a law enforcement official about a death we believe may be the result of criminal conduct; about criminal conduct at PCC; and, in emergency circumstances, to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about individuals enrolled with PCC to funeral directors as necessary for these individuals to carry out their duties.

Military and Veterans. If you are a client of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or the law enforcement official.

OTHER USES OF YOUR MEDICAL INFORMATION: Other uses and disclosures of your medical information not covered by this Notice or required by the laws that apply to PCC, will be made only with your written permission (your written permission is referred to as an Authorization). If you provide your permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons indicated in your written Authorization. You understand that we are unable to take back any disclosures that we made before we received your written notice revoking your Authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical information. This includes your medical and billing records but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

To inspect or obtain a copy of your medical information, you must submit your request in writing to Physicians CareConnection, Inc., 1390 Dublin Rd., Columbus, Ohio 43215, Attention: Privacy Official.

We may deny your request in certain circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by PCC will review your request and the denial. The person conducting the review will not be the same person who initially denied your request. We will comply with the outcome of the review. In addition, if your request for access is denied, PCC will provide a copy of your medical information to a practitioner designated by you in your written request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long the information is kept by or for PCC.

To request an amendment to your medical information, you must submit your request for an amendment, along with your reason for the request, in writing to Physicians CareConnection, Inc., 1390 Dublin Rd., Columbus, Ohio 43215, Attention: Privacy Official.

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 you ask us to amend information that:

(1) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

(2) Is not part of the medical information kept by or for PCC;

(3) Is not part of the information you would be permitted to inspect and copy; or

(4) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of your medical information. This list will not include disclosures that we made for purposes of treatment, payment and health care operations. We are also not required to include in this list the disclosures we made by acting upon your written Authorization.

To request an accounting, you must submit your request, in writing to Physicians CareConnection, 1390 Dublin Rd., Columbus, Ohio 43215, Attention: Privacy Official.

Your request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2004. The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family client or friend.

We are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request a restriction, you must submit your request, in writing to Physicians CareConnection., 1390 Dublin Rd., Columbus, Ohio 43215, Attention: Privacy Official. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work.

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

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 medical information we already have about you as well as any information we receive in the future.

FOR FURTHER INFORMATION: For further information about the matters covered by this Notice, you may contact the Privacy Official at (614) 884-2441.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with PCC or with the Secretary of the U. S. Department of Health and Human Services. To file a complaint with PCC, you must submit your complaint in writing as follows:

Physicians CareConnection
1390 Dublin Rd.
Columbus, Ohio 43215
Attention: Privacy Official

You will not be penalized for filing a complaint.