Inspired Health Group
3671 Southwestern Blvd. Suite 101 & 213
Orchard Park, New York 14127

Office: 716-662-7008
Fax: 716-662-5226

Patient Intake Form

Name: _____ Preferred Name: _____
First Middle Last

Address: _____ _
Street City Zip Code

Birth Date: _____ SS#: _____ Marital Status (Circle One): S M W D SEP DP

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Preferred Method of Contact (Circle One): Home Work Cell All

Email Address: _____ _

Do you have a hearing impairment? (Circle One) Yes No Details: _____

Do you have a vision impairment? (Circle One) Yes No Details: _____

Race (Circle One): White Black/African American American Indian/Alaska Native Asian Native Hawaii/Pacific Islander

Other: _____

Ethnicity (Circle One): Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Unknown

Sex at birth (Circle One): Male Female Unknown

Sexual Orientation (Circle One): Heterosexual Homosexual Bisexual Queer Pansexual Asexual

Other: _____

Gender Identity (Circle One): Male Female Transgender Male Transgender Female

Other: _____

Pronoun (Circle One): He She They We Other: _____

Language (s) Spoken: Primary: _____ Secondary: _____

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____ _

Patient Employer: _____ _

Employer Address: _____ _

Emergency Contact: _____ Emergency Contact Address: _____

Emergency Contact Phone Number: Home: _____ Cell: _____ Work: _____

Emergency Contact Relationship: _____

Please continue on back →

Spouse Name: _____

Do you have a health care proxy? (Circle One) Yes No If yes, please provide the following information for the proxy.

Name: _____ Address: _____

Phone Number: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID #: _____ Group #: _____ Employer: _____

Subscriber Name: _____ Social Security #: _____

Subscriber Date of Birth: _____ Relationship to Subscriber: _____

Secondary Insurance: _____

ID #: _____ Group #: _____ Employer: _____

Subscriber Name: _____ Social Security #: _____

Authorization for Medicare/Insurance Billing

I request that payment of authorized Medicare and/or other insurance company benefits be made payable to Inspired Health Group. I also authorize Inspired Health Group to release any medical information to the insurance carrier for the sole purpose of processing claims and/or determining benefits. All vaccines will be electronically uploaded into NYSIIS, unless verbally refused.

_____

Signature of Patient or Responsible Party Date

IHG Office & Financial Policies & Patient Consent Attestation Form

Inspired Health Group (IHG) is committed to providing you with care and would be happy to discuss our policy with you at any time. Your clear understanding of our Policies is important to our Professional Relationship. Please ask if you are unclear regarding our fees or policies and your financial responsibility.

Identification:

In the interest of protecting against identity theft, we require each patient to regularly present a valid current insurance card and a valid picture ID. A copy of your ID will be scanned into your medical record for this purpose. We request patients inform us immediately of change in phone number, email, home address or health insurance preferably through your Patient Portal.

Pediatric Patients:

Children under 18 years of age must be accompanied by a parent or legal guardian, or with a designated family member or friend if consent has been previously signed and in the child's chart.

Custodial Parent Responsibilities:

The custodial parent/guardian is responsible for payments at the time of service whether the child has insurance or not.

Insurance Participation and Financial Responsibility:

It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements as well as network providers, if applicable. Insurance information must be given to us at the time of service. We will bill insurance companies as a courtesy to you. If we have not received payment from an insurance company within 60 days of the date of service, you will be expected to pay the balance. We provide you with all necessary information to submit your claim to your insurance company. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payment, secondary or tertiary insurances, co-insurance, covered charges, etc. other than to supply your insurance company with necessary information. The Patient is financially responsible for all charges whether or not paid by their insurance company.

Payment Due at Time of Service:

Insurance co-payments are to be made at EACH visit. If you have a high deductible insurance policy, you are required to pay $50.00 at the time of service for each appointment, and we will bill you for the remaining balance. Failure to do so may result in an additional $5.00 surcharge until such time as the deductible has been met. Our practice accepts cash, personal check, Discover, MasterCard, American Express, and Visa. IHG offers telemedicine services, both audio-only and video. As is the case with in-office services, you will be responsible for co-pays, deductibles, and coinsurance not paid by your health plan or insurance for these services. If you are in the office for a visit, it is required to pay part of your outstanding balance if one exists.

Returned Payment Checks

Returned checks will be charged back to the patient's account. There will be an additional $30 service fee for each returned check. We reserve the right to require cash or credit card for future payment on accounts with repeated returned checks.

Private Pay

The office does offer patients with no insurance a flat fee of $100 for an office visit plus any additional charges that may be incurred during the visit. These fees are due at the time of visit without exception.

Late Payments:

If the Patient does not comply with the agreed-upon payment agreement, their account will be considered past due if no payment is received within 30 days of the first account statement. If the account is considered past due, the Patient must make a 50% payment before their next appointment. If the Patient's account balance is beyond 90 days past due, they will be considered as delinquent and their account may be forwarded to a collection agency as well as the Patient being subject to discharge from the practice unless payment arrangements are made and honored. If the Patient balance should go to collections, they will incur an added fee of a minimum of $50.00 to cover the collection company's fee.

Patient Forms:

The patient will be required to pay a $15 fee for any forms that are required to be completed (i.e., disability, FMLA, etc.).

Worker's Compensation:

We do not accept worker's compensation cases. If you are seen for an illness or injury that is worker's compensation related, you will be responsible for payment of services, as these charges cannot be billed to your insurance.

Prohibition of Recording Without Consent:

Any form of recording, including audio, video, or other formats, is prohibited during encounters with any member of this practice, unless explicit written consent is obtained from the person being recorded. Consent must be documented in writing, specifying the purpose and scope of the recording. The individual to be recorded must fully understand and agree to the recording before it takes place. Any violation of this policy may be subject to discharge from the practice.

After Hours:

We provide our own after-hours coverage. IHG providers are available on call after hours and on weekends and holidays for emergencies and urgent medical matters. By calling our office number, our answering service will contact the provider on call. Be sure to disable your call blocking. Please call the office during normal business hours for non-emergency matters.

Emergency Closing:

We notify our answering service when extreme bad weather or other emergency situations force the closure of our office. If possible, we will also notify the local media (Channels 2, 4, 7 and will post on our website at www.IHGWNY.com) if there is a weather emergency that prohibits us from having normal business hours.

Financial Responsibility:

Inspired Health Group is not liable for any purchases or orders made through our office. All sales are final, and items purchased from Inspired Health Group are non-refundable and cannot be exchanged.

Assignment of Benefits and Consent for Treatment:

I hereby assign all medical benefits to include my insurance benefits to which I am entitled, including Medicare, private insurance, and any other plan to Inspired Health Group. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize my physician to perform any medical treatment as deemed necessary.

Cancelled, Rescheduled, and No-Show Appointments:

Patients are required to notify our office at least 24 hours in advance of an appointment to cancel or reschedule, or it is considered a No-Show. If the patient is 15 minutes late or more, it may be considered a No-Show, and they may be required to reschedule and charged a No-Show fee detailed below. No-show appointments limit our ability to provide timely care to other patients and disrupt the workflow of our healthcare professionals. The patient may be reviewed for release from our practice for repeated No-Shows.

No-Show Fee Policy

Our Commitment to Your Health and Time

At our medical office, we value the health, well-being and time of our patients, as well as the time and effort of our healthcare professionals. To better ensure the highest level of service and efficiency, we have established a "No-Show Fee Policy." This policy outlines the expectations and responsibilities regarding appointment attendance and the associated fees for missed appointments.

1. Appointment Confirmation

To serve you better, we kindly request that all patients confirm their appointments by responding to the reminder messages sent by our office in the form of text, email or telephone.

2. Cancellation Policy

If you need to cancel or reschedule your appointment, please notify us at least 24 hours prior to your scheduled time. This allows us to accommodate other patients who may require medical attention.

4. No-Show Fee

In the event of a No-Show as defined above, a No-Show fee will be charged. This fee is intended to partially cover the costs associated with the missed appointment and is not covered by insurance. The no-show fee is as follows:

- Regular office visits: $50
- Extended office appointments: $100 This includes visits for:
    - New Patients
    - Hospital Follow-Ups
    - Medical Clearances
    - Medical Procedures
    - Annual Physicals
    - Annual Wellness Visits
    - Well Child Checks

5. Exceptions

We understand that emergencies and unforeseen circumstances can arise. If you are unable to attend your appointment due to an emergency, please contact our office as soon as possible to discuss a fee waiver or rescheduling options. We will extend an unforeseen circumstances courtesy of 1 no-show per year waiving the no-show fee.

6. Payment of No-Show Fees

No-show fees are expected to be paid before scheduling any future appointments. Payment can be made online through our website, via phone, or in person at the office.

7. Repeated Missed Appointments

Patients who repeatedly miss appointments without proper notice may be subject to additional actions, including the requirement to prepay for future appointments or, in extreme cases, being discharged from the practice. Any individuals that no-shows their New Patient visit twice, will not be offered an opportunity to re-schedule nor accepted into our practice.

8. Questions or Concerns

Our office is committed to clear and open communication. If you have any questions or concerns regarding our No-Show fee policy, please do not hesitate to contact our Billing and Collection Team for clarification.

Sharing Your Health Information:

We participate in CIPA Western New York IPA, Inc. dba Catholic Medical Partners (CMP) and CinqCare which are Independent Practice Associations and is the case of CinqCare; an Accountable Care Association. These are Federally and NYS regulated organizations created to coordinate your care and to reduce unnecessary or duplicate medical procedures or tests. By signing this form, you allow us to share your health information with and receive information from this organization and share with and receive such information from other health care providers who are participating in this organization, in order to coordinate your care. A list of those participating providers and further information can be found at www.catholicmedicalpartners.org. Note that the health information you are allowing us to share may include alcohol and drug treatment information, HIV/AIDS information, mental health conditions, and/or information about sexually transmitted diseases.

Thank you for your anticipated understanding and cooperation with the Office and Financial Polices above. By adhering to these policies, we can better provide the highest quality of care we aspire to, for all of our patients.

I have read, understand and agree with these Inspired Health Group Office and Financial Policies.

Signature: _____ Date: _____

Patient Authorization for Use and Disclosure of Protected Health Information to Inspired Health Group from Another Practice

Memo To:

_____

Phone: _____

(Name of Doctor, Practice, Hospital, Clinic or other Health Care Provider) Fax: _____

_____

(Address City, State, Zip)

Memo From:

_____

(Name of Patient Information is being Requested For/ Date of Birth)

_____

(Address City, State, Zip)

My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you to forward copies of my record:

By signing this authorization, I request and authorize you to release certain protected health information (PHI) about me to:

Inspired Health Group **Phone: 716-662-7008 Fax: 716-662-5226**
3671 Southwestern Blvd., Suite 101
Orchard Park, New York 14127

This authorization permits you to use and /or disclose the following individually identifiable health information about me (specifically describe the information to be released, such as date (s) of services, type of services, level of detail to be released, origin of information, etc.):
All recent progress notes, diagnostics and immunization records.

The following information will not be released unless specifically requested by initialing the item:

_____Chemical Dependency records (records relating to alcohol or substance abuse)

_____Mental health records (including any care for anxiety or depression)

_____HIV related information (signed NYS form 2557 required)

- The information will be used or disclosed for the following purpose: Further medical care.
- This authorization will expire in 90 days. This disclosure can be revoked at your request.
- When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Date of Birth

Health Care Proxy

(1) I, _____

hereby appoint _____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (***Optional: If you want this proxy to expire, state the date or conditions here.)*** This proxy shall expire ***(specify date or conditions):***

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. ***(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)*** I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions ***(attach additional pages as necessary):***

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration ***(nourishment and water provided by feeding tube and intravenous line),*** your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name ***(print)*** _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name ***(print)*** _____

Signature _____

Address _____

_____

NEW YORK STATE | Department of Health

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Weisfogel Sleep Disorder Assessment

Your physician requests that you complete this Sleep Disorder Assessment Form. This form evaluates the ne for you to have a sleep test. The sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date: _____ Name: _____ Date of Birth _____

Phone Number _____ Physician Name: _____

1. Have you ever been given a CPAP device? ..... Yes No
2. If you have been given any form of CPAP, do you use it nightly? ..... Yes No
3. Are you comfortable with your CPAP and satisfied with its use? ..... Yes No

If the answer is "Yes" to all three questions, YOU ARE DONE!

If your answer is "No" to any of the above questions, please continue to *Part 1*.

Part 1 *Epworth Sleepiness Scale*

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. …….. 0 1 2 3
2. Sitting and talking to someone…… 0 1 2 3
3. Sitting and reading…….. 0 1 2 3
4. Watching TV…….. 0 1 2 3
5. Sitting inactive in a public place…… 0 1 2 3
6. Lying down to rest in the afternoon……... 0 1 2 3
7. Sitting quietly after lunch without alcohol…….. 0 1 2 3
8. In a car, while stopped for a few minutes in traffic…… 0 1 2 3

Total ESS: ____

Part 2

1. Have you been told that you snore? ..... Yes No
2. Does your family have a history of premature death in sleep? ..... Yes No
3. Do you have diabetes?..... Yes No
4. Have you ever been told you have coronary artery disease? ..... Yes No
5. Do you have high blood pressure? ..... Yes No
6. Have you ever experienced irregular heart rhythms? ..... Yes No

Part 3

1. Have you ever been diagnosed with sleep apnea? ..... Yes No
2. Do you awaken from sleep with chest pain or shortness of breath? Yes No
3. Has anyone said that you seem to stop breathing while sleeping? .. Yes No
4. Is your neck size larger than 15" (female) or 16.5'' (male)… ..... Yes No
5. Have you ever had a stroke? ..... Yes No
6. Have you ever been told you have congestive heart failure? ..... Yes No
7. Do you have or did you ever have atrial fibrillation? ..... Yes No

Actual Neck Size:

NAME _____ **DATE** _____

CAGE Questionnaire

If you do not drink or use drugs answer no to all questions.

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?

□ **Yes** □ **No**

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

□ **Yes** □ **No**

3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?

□ **Yes** □ **No**

4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

□ **Yes** □ **No**

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been both ered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE ***(add your column scores)***				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire s o far, how difficult have these problems made it for you to do your work, take care of things at home, or get along wi th other people?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Inspired Health Group

3671 Southwestern Blvd
Suites 101 & 213
Orchard Park, NY 14127
www.ihgwny.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: 10/1/2023

This Notice of Privacy Practices applies to the following organizations.
Robert Erickson DO and Jennifer Erickson DO, LLC
DBA: Inspired Health Group

Nancy Smaczniak, Office Manager
nsmaczniak@ihgwny.com
(716) 662-7008