DR. MARY TILAK MD
2241 45th Street Highland IN, 46322
6625 West Lincoln Highway, Crown Point IN 46375
P: 219.922.8051 F: 219.922.8608

Today's Date: _____

PATIENT INFORMATION

Last Name: First Name & Initial:

Social Security#: Sex: Marital Status: (M) (S) (W) (D) Date of Birth:

Street Address:

City: State: Zip:

Home Phone: Cell Phone: Work Phone & Extension:

Email address:

Preferred Language: Race: Ethnicity:

Patient's Employer: (Full) (Part-Time) Student: (Y) (N)

Who Referred You Here Today?

ADVANCED DIRECTIVES

1. Do you have a **LIVING WILL**? YES_____ NO_____

2. Have you appointed a **HEALTH CARE REPRESENTATIVE**? YES_____ NO_____

3. Have you given anyone **POWER OF ATTORNEY**? Yes _____ NO _____

EMERGENCY CONTACT INFORMATION

Last Name: First Name & Initial:

Relationship: Cell Phone: Home Phone:

PHARMACY INFORMATION *(PLEASE INCLUDE CITY AND MAIN ROAD)*

Favorite Pharmacy: Address :

City/Sate: Zip Code:

APPOINTMENT REMINDER PREFERENCES

Primary contact number: Primary form of Contact: Circle ONE only (Text) or (Call)

Preferred time of day to call, if applicable: (Morning) (Afternoon) (Evening)

Enable email notification: (must be web enabled by providing email address) Yes / No

PRIMARY INSURANCE *(IF YOU ARE NOT THE POLICY HOLDER PLEASE FILL OUT THIS SECTION)*

Name of Insurance: Policy Holder's Name:

Policy Holder's DOB: Policy Holder's Social Security:

SECONDARY INSURANCE *(IF YOU ARE NOT THE POLICY HOLDER PLEASE FILL OUT THIS SECTION)*

Name of Insurance: Policy Holder's Name:

Policy Holder's DOB: Policy Holder's Social Security:

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Financial Policy

I. **CONSENT TO TREAT:** I request and give consent to Mary Tilak, MD and associates to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by Mary Tilak, MD and associates for my health and wellbeing. I acknowledge that no representation, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

II. **RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** I authorize Mary Tilak, MD and associates or any other authorized person (s) to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I understand that if I refuse consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

III. **AUTHORIZATION FOR ASSIGNMENT OF BENEFITS & FINANCIAL OBLIGATION:**

- **a.** In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician(s), including Medicare Part B.
- **b.** I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance within sixty (60) days I will receive a letter and phone call stating that I will have 10 days to make a payment in full and failure to do so will result in my account being placed in collection. I understand partial payments will not be accepted and will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to insufficient funds.

IV. **INSURANCE:** We participate in most insurance plans, including Medicare. We must obtain a copy of your current insurance card and a valid ID in order to process claims appropriately. If your insurance changes please notify us at your next visit. It's your responsibility to know your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage.

V. **NON-COVERED SERVICES:** Please be aware that some – and perhaps all – of the services you receive may be not be covered by Medicare or other insurers. You are encouraged to discuss with your provider regarding the necessary testing. You must pay for these services in full at the time of visit or after the denial has been received from insurance

VI. **CO-PAYMENTS, DEDUCTIBLE AND CO-INSURANCE:** I understand that if my medical insurance requires a copay, deductible or co-insurance, it is due at the time of service.

VII. **MISSED APPOINTMENTS**: It is our policy to charge any patient who fails to cancel or reschedule 24 hours prior to their scheduled appointment. You will be charged a no show fee of $25. You can cancel or reschedule your appointments via telephone or patient portal.

VIII. **REFUNDS*:*** Patient overpayments will be refunded within 30 business days of patient request**.**

IX. **NO INSURANCE:** Ask about our affordable cash pay options.

*Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area**.***

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient Signature **Date**

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to: conduct, plan and direct my treatment and follow-up among the multiple health providers who may be involved in treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understood your Notice of Privacy Practices (NPP). I understand that this organization has the right to change its NPP and that I may contact this organization at any time at the address above to obtain a current copy. I understand that I may request in writing that Mary Tilak, MD restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Mary Tilak, MD is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions.

Patient Name _____ Date_____

Signature _____

Relationship to Patient (if not signing for self) _____

Authorization To Release Information

I give consent and authorization for the medical, or billing staff of my physician's office to release information regarding my medical care such as appointment times, lab order and or prescriptions to the following people below. If at any time, I want to withdrawal or add a person to the list, I understand I must come into the office and refill out this form.

Name: ***Relationship:***

_____ _____

_____ _____

_____ _____

Release Of Protected Health Care Information Via Voice Mail

I give my consent and authorization for the Medical, or Billing Staff of Mary Tilak, MD to leave protected health care information about me or for me on my answering machine or voice mail via the telephone at the number I have listed. I understand I may revoke the privilege at any time by submitting my request in writing to the office. If I choose not to authorize release via the telephone, I understand, I am responsible to call the office to retrieve results of all tests and procedures.

Phone Number:_____ Signature: _____
Any Restrictions:_____

I understand I may revoke this privilege listed at any time by submitting my request in writing to this office.

Signature: _____ **Date:** _____

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Authorization to Obtain Personal Medical Records

I authorize (facility name) _____
(phone) _____ **to release my medical records/information to Dr. Tilak's office.**

Name of Patient: _____ **DOB:** _____

Please send:

- Radiology Procedures and Reports
- Laboratory Reports
- Consultations
- Other Test
-

Purpose: _____

***Note to patient*:** *if we are requesting this authorization from you for our own use and disclosure or to allow another health care provider of health plan to disclose information to us:*

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization
- You may inspect a copy of the protected health information to be used or disclosed
- You may refuse to sign this authorization
- We must provide you with a copy of the signed authorization

Unless revoked earlier or otherwise indicated, this authorization will expire in 1 year from the date of signing. *You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. It shall remain in effect for the period reasonably needed to complete the request.*

Sign: _____ **Date**: _____

Mary Tilak, MD
Medical Histoy / Historial Medico

HOSPITALIZATION: If you have been in the hospital overnight and/or had surgery list the year type of illness or surgery.
HOSPITALIZACIÓN: Si hay estado en el hospital durante la noche y tuvo cirugía liste la enfermedad o cirugía y el año

Do not include normal pregnancies. Please start with most recent event.
No incluyen embarazos normales. Por favor comience con el más reciente evento.

Year / Año	Illness or Operation / Enfermedad o operación	Year / Año	Illness or Operation / Enfermedad o operación

PAST MEDICAL & FAMILY HISTORY: Please check if you (self) or any blood relatives had any of the following conditions:
HISTORIAL PASADO FAMILIAR Y MEDICO: Marca **s**i usted (uno mismo) o parientes tenían cualquiera de las siguientes condiciones:

	Self /Uno Miso	Relative /Pariente
1)Recent Weight Loss / pérdida de peso reciente		
2)Migraine Headaches / migraña		
3)Epilepsy/Convulsions / epilepsia /convulsiones		
4)Eye Disease (except glasses) / enfermedad de los ojos (excepto lentes)		
5)Hearing Disorder / Trastorno auditivo		
6)Recurrent Nose Bleeds / Sangrado nasal recurrente		
7)Recurrent Throat/Sinus Infection / Infección de garganta / sinositis recurrente		
8)Angina or Chest Pain / angina de pecho o dolor en el pecho		
9)Heart Attack / Ataque cardíaco		
10)High Blood Pressure / Presión arterial alta		
11)Stroke / Derrame Cerebral		
12)High Cholesterol / Colesterol alto		
13)Heart Valve Disorder / Trastorno de la válvula de corazón		
14) Lung Disease / enfermedad pulmonar		
15)Stomach Ulcer / Úlcera de estómago		
16)Bowel Problems / Problemas intestinales		
17)Liver Disease of Hepatitis / enfermedad del hígado o hepatitis		
18)Kidney/Bladder Problems / Problemas de riñón vejiga o urinaria		
19)Neurological Problems / Problemas neurológicos		
20) Arthritis / artritis		
21)Osteoporosis / osteoporosis		
22)Cancer –list type below on blank space / Cáncer– liste el tipo abajo en espacio blanco		
23)Bleeding Disorder / Trastorno de sangrado		
24)Blood Transfusion (s) / Transfusión de sangre (s)		
25) Anemia / anemia		
26) Diabetes / diabetes		
27)HIV/AIDS / VIH o SIDA		
28) Hypertension / hipertensión		
29)Thyroid Problems / problemas de la tiroides		
30)Alcohol or Drug Abuse / abuso de alcohol o drogas		
31)Mental Illness / Enfermedad Mental		
32)Depression / Depresión		
33)Psoriasis or Eczema / psoriasis o eczema		
34) Asthma/Other Resp. Dis. / asma o enfermedad de las vías respiratoria		

CANCER TYPE/ TIPO DE CANCER:

MEDICATIONS: List all medication you are currently taking. Use blank page if more room is needed.
MEDICAMENTOS : Lista todos los medicamentos que está tomando actualmente. Página en blanco atrás si es necesario más espacio.

ALLERGIES: list all drug allergies
ALERGIAS : lista todas las alergias de drogas si tiene

Medication / Medicamento	Strength / Fuerza	Time/Day Hora/día	

WHEN WAS THE LAST TIME YOU HAD: Enter year
CUÁNDO FUE LA ÚLTIMA VEZ QUE TUVO : Ponga el año a lado del examen

	YEAR / AÑO
Flu Shot / Vacuna de Gripa	
Eye Exam / Examen de Ojos	
Pneumonia Shot / Vacuna de neumonia	
Hepatitis Vaccine/ Vacuna de Hepatitis	
T. B. Test / Examen de T.B.	
Stool Test for Blood / Prueba de sangre oculta	
Rectal Exam/ examen de cancer rectal	
Tetanus Shot / Vacuna de tétano	
Cholesterol Test / Prueba de colesterol	

YOUR HEALTH HABITS / SUS HÁBITOS DE SALUD

Please mark none if habits do not apply to you.
Favor de marcar nada si los habitos no pertenecen a usted.

None/Nada ( )
Caffeine/Cafeina: ____Cups/Day Vaso/dia ( )
Smoke /Fumar: _____ Packs/Day paquete /dia ( )
Years since quitting / Años desde que paro_____
Alcohol: _____Drinks/Week Bebida/semana ( )
Drugs/drogas:_____ ( )
Other/ otro: _____

FOR WOMEN ONLY/ SOLO PARA MUJERES:

Number of Pregnancies Número de embarazos _____
Number of Births / número de nacimientos _____
Number of Miscarriages / número de aborto _____
Number of abortions / Número de abortos _____
Date of Last Menstrual Period/ Fecha de última menstruación: _____
Are you on Birth Control/ Estás usando contraceptivos: (Yes)/(Si) (No)
If so, what type / si es si, cual tipo: _____
Year of Last / Año del ultimo:
Pap Test / Papanicolau: _____ ___Normal or /o ___Abnormal
Breast Exam / Exam de senos:____ ___Normal or /o__ Abnormal
Mammogram /mamograma _____ ___Normal or /o ___Abnormal

Name any specialist you have seen below: (I.E. Cardiologist, Pulmunologist)
Nombre los especialistas que han visto: (Es decir, cardiólogo, neumólogo)

Name/Nombre	Specialty/ Especialidad

Patient Name / Nombre de Paciente : _____ Birthdate/Dia de nacimiento: ____/____/_____

Notice of Privacy Practice

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

Effective Date of Notice: December 22, 2016

A. Our Commitment to Safeguard Your Health Information;

Mary Tilak P. C. is dedicated to maintaining the privacy of your protected health information. Protected health information in any form about your past, present, or future health condition, the health care provided to you, or the past, present or future payment for your health care, and includes identifiers that do or could be used to identify you.

Our Office is required to maintain the privacy of your protected health information and to provide you with a copy of this Notice of Privacy Practice. This Notice Describes our health information privacy practices, and other health care providers with whom we participate in order to conduct quality improvement or operational activities.

This Notice applies to Mary Tilak P.C., including all employees, staff or volunteers with whom health information is shared to provide your health care services, as well as, third parties with whom we may share your health information to assist us in performing a service or function on behalf of our Office.

Our Office reserves the right to change its privacy practices and the terms of this Notice at any time. In the event we materially change a privacy practice, the change will be effective for all information already maintained about you, and the revised Notice will be promptly posted. You may also request a copy of the Notice currently in effect from Caitlin Ryder at 219-922-8051. You can also access a copy online at www.marytilakmd.com.

If you have any questions about the content of this Notice, please contact Brianna Surowiec at 219-922-8051.

B. How Your Protected Health Information May Be Used or Disclosed:

We have the right to use or disclose your protected health information for treatment, payment, or health care operational activities, and under certain circumstances, the law may require us to disclose your protected health information. We may disclose your protected health information to a third-party to perform a function or service on behalf of our office, but before doing so, we will have a written agreement in place that extends the same privacy protection to your health information that we must apply. Business associates have a statutory obligation to comply with the terms of such agreements. Listed below are descriptions and examples of other uses or disclosures we may make of your protected health information.

1. Disclosures Related to Treatment, Payment or Operational Activities:

Treatment. Your protected health information may be used or disclosed to provide or manage your health care and related services, coordinate or mange your health care with a third-party, consult with other health care providers, or refer you form on health care provider to another. For example, if you have diabetes and suffer a broken leg, your doctor may refer you to another physician who specializes in treating patients with diabetes, or your doctor may coordinate your health care with a dietician who will use your protected health information to provide an appropriate meal plan for you. We routinely disclose your protected health information to any future health care providers upon verification of the request for your information.

Payment. Your protected health information may be used or disclosed to obtain

reimbursement for health care services provided to you. For example, your protected health information may be used to contact your health insurance company to determine if your insurance company will cover or pay for your treatment.

Health Care Operations. Your protected health information may be used or disclosed for operation purposes. These uses and disclosures are important to ensure that you are provided health care services in an efficient and cost-effective manner. For example, your protected health information may be used to determine additional services you may need; to evaluate the care you received; to evaluate the competence or qualification of a health care professional; to conduct or arrange for medical review or legal services; or for business planning and development. The Office also is a participating provider in the CHP, a clinically integrated network operating in Northwest Indiana. We may share your protected health information with CHP to aid in its initiatives to improve quality of care and control cost. Your protected health information may be stored and exchanged electronically for these purposes.

Appointment Reminders and Other Messages. Your protected health information may be used to remind you of an appointment or to contact you about a cancellation, to schedule a test or to contact you in an emergency. To do so, we may leave a message at your home or an alternate telephone number you have provided. In most circumstance, the message we leave will be limited to a telephone number for you to call us back. Under certain circumstances, however, in order to inform you of the purpose of our call, we may leave more detailed information.

Treatment Alternatives. Your protected health information may be used to provide you with information about treatment alternatives.

Health-Related Benefits and Services. Your protected health information may be used to provide you information about other health-related benefits or services that may be of interest to you.

Marketing. Your protected health information may be used to tell you about a health-related product or service that is provided by our Office. For example, we may communicate with you about a product or service about treatment you are receiving; to coordinate your care and treatment; or to recommend alternative treatment, health care providers or alternate setting where you can receive health care. If our Office receives any financial remuneration your written authorization is required.

Minimum Necessary. When using or disclosing protected health information, we will limit the use, disclosure, or request to a limited data set to the extent practicable or, if needed, to the minimum amount of protected health information that excludes your direct identifiers (listed in 45 CFR §164.514€(2)) or those of your relatives, employers or household members. The minimum necessary standard will not apply in the following situations:

1. Disclosures to or request by healthcare provider for treatment;
2. Uses or disclosers made to you;
3. Uses or disclosures made pursuant to your authorization
4. Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
5. Uses or disclosures that are required by law; and
6. Uses or disclosures that are required for our compliance with legal regulations.

2. You May Agree or Object to The Following Uses and Disclosures of Your Protected Health Information:

Release of Protected Health Information to a Family Member, Friend, or Other

Persons Involved in Your Care and Treatment or for Notification Purposes. Protected health information about you may be disclosed to a family member, relative, close personal friend or any other person identified by you, only to the extent the health information is relevant to that person's involvement with your care or payment for your healthcare.

Your protected health information may also be used or disclosed to notify or assist in notifying a family member, personal representative or any other person responsible for your care of you location or general condition.

Disaster Relief. We may disclose your protected health information to a public or private entity authorized by law to assist in disaster relief efforts for the purpose of notifying or assisting in notifying a family member a personal representative, or another person of your location and general condition.

3. **Other Uses or Disclosures of Your Protected Health Information:**

Required by Law. Your protected health information may be disclosed when the use of disclosure is required by law.

Public Health Activities. Your protected health information may be disclosed for public health activities. For example, your protected health information may be disclosed to prevent or control disease, injury or disability; report child abuse or neglect; maintain vital records, such as births and deaths; notify a person regarding potential exposure to a communicable disease; notify a person regarding a potential risk for spreading or contracting a disease or condition; notify an appropriate government agency about the abuse or neglect of an adult individual (including domestic violence); or to the federal Food and Drug Administration (FDA) to report adverse events with medications and track regulated products, report product recalls, defects or replacements

Abuse, Neglect, and Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, or domestic violence, to the extent the law reviews, protected health information about you may be disclosed to an agency authorized by law to receive such reports.

Health Oversight Activities. Your protected health information may be disclosed to a health oversight agency to perform oversight activities authorized by law or for appropriate oversight of the health care system; for example, audits, investigations, inspections, and licensure activities.

Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding. For example, we may disclose your protected health information in response to a court or administrative order, or in response to a discovery request, subpoena or other lawful process.

Law Enforcement. Your protected health information may be disclosed to a law enforcement official to report certain types of wounds or other physical injuries; to identify or locate a suspect, fugitive, material witness or missing person; to provide certain information about the victim of a crime, about a death due to criminal conduct, or about criminal conduct at our Office; and in emergency circumstances, to report a crime, the location of a crime, to identify the victim of a crime, or the identity, description or location of the person who committed the crime.

To Avert a Serious Threat to Health or Safety. Your protected health information may be disclosed to reduce or prevent a serious threat to your health and safety or the health and safely of the public or another person. For example, to prevent or control disease; report child abuse or neglect; report reactions to medications or problems with products; notify a person regarding potential exposure to a communicable disease; notify people of recalls or products they may be using; in response to a warrant, summons, court order, subpoena or similar

legal process; identify/locate a suspect, material witness fugitive or missing person; or in an emergency, to report a crime or the description, identify or location of the perpetrator

Military and Veterans. If you are a member of the armed forces, your protected health information may be disclosed to an appropriate military command authority to assure proper execution of a military mission.

National Security and Intelligence Activities. Your protected health information may be disclosed to federal official for intelligence and national security activities authorized by law; to protect the President, other officials or foreign heads of state; or to conduct an investigation.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement official, your protected health information may be disclosed to the correctional institution or a law enforcement official as necessary for the institution to provide you with health care, protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Workers' Compensation. Your protected health information may be disclose for workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.

C. Your Rights Related to Your Protected Health Information;

Right to Inspect and Copy. You have the right to inspect and obtain a copy of information used contained In the Designated Record set for a period of seven (7) years as required by state law. You may be charged a fee for the cost of copying, mailing, labor and supplies associated with your request. To inspect and copy the Designated Record Set, you must submit your request in writing to the Office listed on Page seven (7) of this Notice. "Designated Record Set" includes the medical records and billing records about individuals maintained by or for the Office that is used in whole or in part to make decisions about an individual's healthcare.

In the event we have your protected health information in an electronic health record (EHR), then we may be required to provide your protected health information to you in electronic format.

The requested information will be provided to you as soon as reasonable possible, but no later than 60 days after your request. We may deny your request to inspect or copy in certain limited circumstances; however, you may request a review of the denial. Reviews will be conducted not by the person that denied your request, but by another licensed health care professional.

Right to Amend. You have the right to request us to amend your protected health information in a Designated Record Set for a period of seven (7) years as required by state law. Your request must be in writing and you must provide a reason that supports your request. Your request must be submitted to the Office listed on page seven (7) of this Notice.

We will act on your request as soon as reasonably possible, but no later than 60 days after your request. We may deny your request if the information of record you wanted amended was not created by us; is not part of the Designated Record Set kept by us; is not part of the Designated Record Set which you would be permitted to inspect or copy; or if the information contained in the Designated Record set is accurate and complete

Right to an Accounting of Disclosures. You have the right to request a list of those instances where your protected health care information has been disclosed by us in the six years prior to the date of your request. The accounting will reflect disclosures other than those; i) for treatment, payment or operational activities; ii)) to you or as authorized by you; iii) to persons involved in you care or treatment; iv) for national security or intelligence activities; v) to correctional institutions or law enforcement officials; vi) incident to a disclosure we are required to make; or vii) made prior to April 14, 2003. To obtain an accounting of disclosures, you must submit your request in writing to the Office

listed on page seven (7) of this Notice. If you request more than one accounting within a 12-month period, we will charge a reasonable, cost-based fee for each accounting after the first one.

Right to Request Restrictions. You have the right to request a restriction of the use or disclosure of your health information for i) treatment, payment or operation activities; ii) to individuals involved in your care of the payment for your care, such as family members or friends. You must make your request in writing to the Office listed on page seven (7) of this Notice. Your request must describe in a clear and concise fashion: i) the information you wish restricted; ii) whether you are requesting a limit on the use of the health information for treatment, payment or operational activities, or whether you are requesting a limit of the disclosure of the information to family members or friends, or both; and iii) to whom you want the limits to apply.

We are not required to agree to your request for restrictions unless the request is to a health plan to restrict the disclosure for purposes of carrying out payment or healthcare operations only (and is not otherwise required by law) and the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full. If we agree to a restriction, we are bound by the agreement, except when otherwise required by law, in emergencies or when the information is necessary to treat you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health and health-related issues in a particular manner or at a certain location. For instance, you may ask to be contacted by mail rather than by telephone, or at home rather than work. In order to request a type of confidential communication, you must submit a request in writing to the Office listed on page seven (7) of this Notice. Your request must specify the alternate method of contract you are requesting or the location where you wish to be contacted. You do not need to give a reason for your request. We will accommodate reasonable request.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of this Notice at any time by contacting the Office listed on page seven (7) of this Notice.

Right to File a Complaint. If you are concerned that your privacy rights may have been violated, you may file a complaint in the Office listed on page seven (7) of this Notice or the Secretary of the Department of Health and Human Services' Office of Civil Rights. Their contact information is: HHS Secretary US Department of Health & Human Services- OCR 200 Independence Avenue, SW Washington, DC 20201 email: OCR Mail@hhs.gov .You will not be retaliated against for filing a complaint.

Right to Receive Notice of Breach. We are required to notify you if your protected health information has been breached. This notification must occur by regular mail no later than 60 days after we discover the breach. If a breach involves more than 500 residents of the State of Indiana, we must also notify the Secretary of the department of Health and Human Services and prominent local media outlets of the breach. A breach occurs when there has been an unauthorized acquisition, access, use, or disclosure of protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which compromises the privacy or security of protected health information. The notice must:

1. contain a brief description of what happened, including the date of breach and the date of discovery;
2. the steps an individual should take to protect themselves from potential harm resulting from breach;
3. A brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

An impermissible use or disclosure of protected health information will be presumed to constitute a reportable breach unless it can be shown that a low probability exists that the protected health information was compromised as a result of the impermissible activity. We are not required to give notice upon the occurrence of any of the following.

1. Any unintentional acquisition, access of use of protected health information by our employee or person acting under the authority of the Office or one of the Office's business associates, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by HIPAA.

2. Any inadvertent disclosure by a person who is authorized to access protected health information Office or business associate of the Office to another person authorized to access protected health information within the Office or the same business associate, and the information received as a result of such disclosure is not further used or disclose in a manner not permitted by HIPAA.
3. A disclosure of protected health information where the Office or a business associate of the Office has a good faith believe that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

D. Other Uses of Protected Health Information;

Authorization. Most uses and disclosures of psychotherapy notes, uses and disclosures of your protected health information for marketing purposes where we receive financial remuneration and disclosures that constitute the sale for protected health information require your written authorization. Other uses and disclosure of medical information not covered by the Notice will be made only with your written authorization. You may revoke an authorization for the use of disclosure of your protected health information in writing at any time. Your request should be made in writing to the Office listed on page seven (7) of this Notice. If you revoke the authorization, your protected health information will no longer be used or disclosed for the reasons covered by your written authorization; however, the revocation will not apply to any disclosure already made with your authorization.

Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information, including any part of your protected health information that is: (1) kept in psychotherapy note; (2) about mental health and developmental disability services; (3) about alcohol and drug use prevention, treatment and referral; (4) about HIV/AIDS testing, diagnosis or treatment; (5) about venereal disease; (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; or (9) about sexual assault. Before we share your highly confidential information for a purpose other than those permitted by law, we must obtain your written permission.

Our office is a participating provider in Community Healthcare Partners ("CHP"), a clinically integrated network operating in Northwest Indiana. The office may share your protected health information with CHP to aid in initiatives to improve quality of care and control costs. Your protected health information may be shared and exchanged electronically for these purposes.

If you would like to opt-out of sharing your PHI with CHP, please ask the front desk for the directions to opt-out.

E. Changes in this Notice;

If we make a material change to this notice, we will provide a revised notice in the Office and on the website www.marytilakmd.com.

F. If you are making a complaint or need more information about Mary Tilak P.C., please contact the applicable entity:

Mail:
Mary Tilak, MD
2241 45TH St.
Highland, IN 46322

Phone:
219-922-8051 and ask for either contact stated below

Brianna Surowiec
Office Manager

Caitlin Ryder
Operational Excellence Coordinator