Welcome to Corrective Care!

We are honored to have you join us and appreciate the faith of those who have entrusted you into our care. We strive to find solutions to even the most difficult pain problems and promise to do our best to help with ***yours***.

To make your initial visit as productive as possible, we are sending you our *patient information packet* ahead of time. We think you will find it much easier to fill out the information requested at your leisure, in the comfort of your own home, rather than in our reception area with a clipboard perched unsteadily on your knees. Having the paperwork out of the way *before* you get here makes the visit easier on everyone and allows the physician to spend more of your valuable appointment time providing the medical care you need.

Please remember to bring this packet - and, your insurance card and photo ID when you come to your appointment. If you have current x-rays, MRI or other lab/test results, we encourage you to bring them with you as well. If you need assistance locating your lab work/test results, please let us know, perhaps we can help.

If you have group health insurance, we will be happy to file primary insurance for you and will collect your co-pay at time of service.

If you are *not* covered by medical insurance, please be advised that we will require payment at time of service. For your convenience, we accept cash, personal check, money order, Visa, MasterCard, Discover and American Express credit cards. If monthly payment terms are needed, we offer several no interest/low interest CareCredit financing options.

The initial evaluation is a very thorough one and usually takes about an hour. We suggest you dress comfortably in something that allows flexibility and provides easy access for the doctor's examination.

We encourage you to visit our website www.correctivecare.com if you're interested in learning a little more about us before you come. I'm sure it will answer most of the questions you have about our practice.

We are enclosing a map and written directions in case you need them. Mishawaka, Indiana is on Eastern Daylight Time. – something to keep in mind when planning your travel time here.

Our office hours are 8:00am. to 6:30p.m. Monday through Thursday and 8:00a.m. to 12:00 noon on Fridays. Please feel free to call us any time we can be of assistance.

Corrective Care Staff

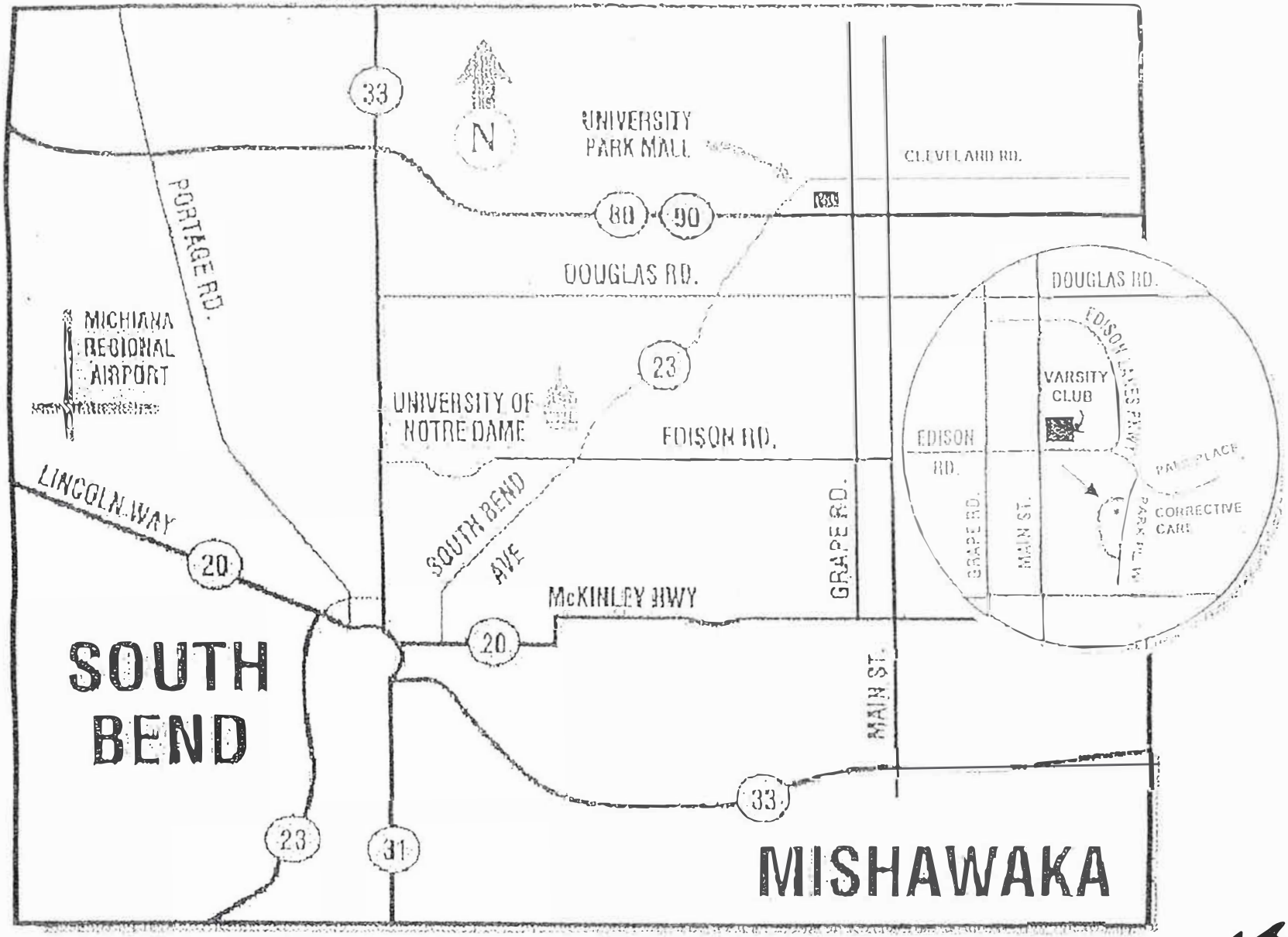
Coming from the East (Ohio) or West (Illinois): Exit from the **Indiana Toll Road (I-80/90)** at the **Mishawaka Exit** *(Exit # 83).* At the stop light at **Capital**, turn left (south) and go to **Day Road**, turn right on **Day Road** go to **Main Street**, turn left on **Main Street**, your next light will be **Edison Road**, turn left onto **Edison Road** (*Varsity Club Hotel will be on your left*). Follow Edison Road to **Park Place** (*the second right turn—first right is a driveway; second right is a street).* Turn right on **Park Place** following the road as it curves slightly. Turn right at the second street (*also called Park Place)* into the corporate office complex "*Park Place at Edison Lakes*." We are in the third building on the right-hand side –3555 Park Place West, Suite 200.

Coming from the South (Indianapolis): Take **U.S. 31** North. Just south of South Bend, take the **U.S.20/U.S. 31 Bypass** East toward Mishawaka/ Elkhart. Take the second exit, **State Road 331** (Mishawaka) and go North through Mishawaka. (Note: SR 331 will wind around and have various street names: first Union Street, then Church Street, and finally Main Street. At U.S. 20 (McKinley Avenue), SR 331 will end but Main Street continues north). Stay on **Main Street** to Edison Road (third light past McKinley). Turn right on **Edison Road** (Varsity Club Hotel will be on your right) and follow Edison Road to **Park Place** (*the second right turn—first right is a driveway; second right is a street).* Turn right on **Park Place** following the road as it curves slightly. Turn right at the second street (*also called Park Place)* into the corporate office complex "*Park Place at Edison Lakes*." We are in the third building on the right-hand side –3555 Park Place West, Suite 200.

Coming from the North (Michigan): Take the **U.S. 31 Bypass** South from Michigan to the first Indiana exit **(Cleveland Road/Brick Road Exit).** At the base of the exit ramp, turn left (East) on **Cleveland Road.** Stay on **Cleveland Road** for approximately five miles (**past U.S. 31/U.S.33 Business Route, Ironwood and Grape Road)** to **Main Street** (first stoplight after **Grape Road).** Turn right (south) on **Main Street** and go two miles to **Edison Road** (Varsity Club Hotel will be on your left). Turn left & follow Edison Road to **Park Place** (*the second right turn—first right is a driveway, second right is a street).* Turn right on **Park Place** following the road as it curves slightly. Turn right at the second street (*also called Park Place)* into the corporate office complex "*Park Place at Edison Lakes*." We are in the third building on the right-hand side –3555 Park Place West, Suite 200.

Mark S. Cantieri, D.O., F.A.A.O.
Edison Lakes Corporate Park
3555 Park Place West Suite 200
Mishawaka, IN 46545
(574) 271-8646 Office
(574) 271-8624 Fax

Corrective Care, 3555 Park Place West, Mishawaka, IN 46545



(219) 271-8646

CORRECTIVE Care, PC

Corrective Care

INSURANCE VERIFICATION

Your appointment has been scheduled for: _____ with Dr. _____

Before your visit you need to call your group health insurance company to verify coverage.

This information will play an important part in helping your doctor design a treatment plan that is not only best suited to meet your medical need, it will be one you are able to afford financially. As you know, if your insurance company does not pay for the medical treatment given, YOU will have to (an important reason to take the time to check what's likely to be covered before you come.)

~ **The telephone number to call to verify benefits is shown on the back of your health insurance card.** ~

Patient's Name: _____ **Insurance Company Name:** _____

~ *The following is a list of questions to ask when you call:* ~

1. **Insurance effective date:** _____ **Policyholder's Name:** _____

2. **Is Dr. Mark Cantieri in my network?** (Fed. ID # 35-1913616) _____ yes _____ no

3. **Co- Pay:** $_____ **or** **Co-insurance:** ____90/10 ___80/20 ___70/30 ____60/40 _____ Other
(for office visit to a specialist) (Note: you should have either a co-pay or co-insurance ... Not both)

4. **Is a referral required to see a specialist?** _____ yes _____ no

5. **Does treatment require pre-approval?** (see treatment options listed below)
Osteopathic Manipulation ___ yes ___ no Surgical Injections ___ yes ___ no Physical Therapy _____ yes _____ no

6. **Is Osteopathic Manipulation covered?** (Code # 98925) _____ yes _____ no
(our physicians are D.O.'s - not chiropractors)

7. **Are out-patient surgical injections covered?** (Procedure code examples shown below) _____ yes _____ no
(Ligament {code # 20550}, Tendon {code # 20551}, Trigger Point {code # 20552}, Joint {code # 20600} or Paravertebral {code # 64490})
Comment: _____

8. **Are Prolotherapy Injections covered?** (Procedure code MO076) _____ yes _____ no

9 **Is physical therapy covered?** _____ yes _____ no # visits allowed per calendar year: _____
Comment: _____

10. **Is there a separate co-pay for Physical Therapy visits?** _____ yes _____ no $_____

11. _____ _____ _____ _____
Name of Person Who Verified Your Coverage Telephone Number You Called Date Time

~ **If you find out that either a referral or pre-authorization is needed, please call our office at least two days before your scheduled appointment date to let us know.** ~ **Thank You.**

Corrective Care, PC
Mark S. Cantieri, DO, FAAO

Infant/Mom New Patient Questionnaire

Name of child:

Date of Birth:

Female/Male

What is your concern regarding your infant?

Mom, have you had any previous children? Yes/No How many?

Was this an easy pregnancy? If no, why not.

Was this an easy delivery? Forceps or vacumn extraction? Induced with Pitocin?

APGAR scores if known:

Has the child had any issues? Colicky, poor sleep, restless, irritable, feeding difficulties, recurrent infections, allergies or other medical concerns?

Is your infant taking any medications or supplements?

Any surgeries or illnesses?

Any other things you would like to add?

REVIEWED BY
PHYSICIAN: _____

Function Index (continued)

Are you able to do all of your activities of daily living yourself (bathing, dressing, etc,) ? [ ] Yes [ ] No
Please list those you cannot perform _____
Do you participate in any housework (laundry, cooking, cleaning, etc.) ? [ ] Yes [ ] No
If so, what chores? _____

PRIOR SURGERIES

	Procedure	*Date*
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Women Only Menstrual Cycle:
Age at onset _____
Regular [ ] Yes [ ] No [ ] Rarely
Cycle (from start to start) Duration _____days
Pain or cramps [ ] Yes [ ] No
Date of last period _____

Pregnancies:
Number _____
Complications with any pregnancy? [ ] Yes [ ] No
What?_____
Did you have back pain with pregnancy? [ ] Yes [ ] No
Does it hurt to have intercourse? [ ] Yes [ ] No
Do you enjoy your sex life? [ ] Yes [ ] No

FAMILY HEALTH HISTORY

Have any family relatives (mother, father brother, sister, grandfather, grandmother, aunt, uncle, cousin, nephew, niece, son, daughter, in-laws) suffered any of the following: (please list the people relative to their relationship to you)

Condition	*Relationship to you*
Cancer	_____
Obesity (overweight)	_____
High Blood Pressure	_____
Heart Trouble	_____
Stroke	_____
Asthma	_____
Allergies	_____
Diabetes (sugar)	_____
Ulcers	_____
Stomach or Bowel Problems	_____
Gout	_____
Kidney Disease	_____
Arthritis	_____
Hay fever	_____

Condition	*Relationship to you*
Nerve/Muscle Diseases	_____
Seizures (fits, epilepsy)	_____
Anemia (low blood)	_____
Bleeding Problems	_____
Rheumatic Fever	_____
Alcoholism	_____
Mental Illness	_____
Physical Deformity	_____
Blind/Deaf	_____
Mental Retardation	_____
Hereditary Problem	_____
Death by Accident	_____
Other Problems not mentioned above	_____
	_____

PLEASE PRINT

TODAY'S DATE _____ **PATIENT REGISTRATION** FORM 1001-REV. 9/00

PLEASE COMPLETE ALL WHITE AREAS

PATIENT INFORMATION

The person seeing the doctor.

PATIENT NUMBER							
LAST NAME		FIRST NAME & INITIAL					
ADDRESS LINE 1							
ADDRESS LINE 2		E-MAIL:					
CITY		STATE		ZIP			
HOME PHONE		CELL PHONE:					
SEX		MARITAL STATUS (M/S)		DATE OF BIRTH		M.D. REQUESTING YOUR APPOINTMENT	
PATIENT'S S.S. NO.		IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW ☐ PATIENT ☐ YELLOW PAGES ☐ PROVIDER BOOK ☐ OTHER					
PATIENT'S EMPLOYER							
EMPLOYER ADDRESS							
CITY		STATE		ZIP			
EMPLOYER PHONE		EXT.					

GUARANTOR

Person responsible for all unpaid balances on this account.

RESP. PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
CITY		STATE		ZIP		E-MAIL ADDRESS	
HOME PHONE		CELL PHONE		E-MAIL			
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.					
RESP. PARTY EMPLOYER		EMPLOYER PHONE		EXT.			
EMPLOYER ADDRESS		EMPLOYER FAX #					

INSURANCE

List all Insurance for which you have a current card. List Medicare or Medicaid first.

MEDICARE, OR INS. #1 NAME			INS. #1 CODE	
INSURANCE #1 ADDRESS			INS. #1 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP	
CERTIFICATE #		GROUP NO.	MEMBER NO.	
INSURANCE #2 NAME			INS. #2 CODE	
INSURANCE #2 ADDRESS			INS. #2 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP	
CERTIFICATE #		GROUP NO.	MEMBER NO.	
INSURANCE #3 NAME			INS. #3 CODE	
INSURANCE #3 ADDRESS		FIRST NAME	INS. #3 PHONE	
POLICYHOLDER LAST NAME		GROUP NO.	RELATIONSHIP	
CERTIFICATE #			MEMBER NO.	

Spouse, step-parent, significant other

NAME		E-MAIL:	
DATE OF BIRTH	CELL #:	S.S. NO.	
EMPLOYER		WORK PHONE	
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE	

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

CONSENT TO TREAT: I request and give consent to my physician/physical therapist to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician/physical therapist. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician/physical therapist to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician/physical therapist, on my behalf.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician/physical therapist who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician/physical therapist treating me, on my behalf.

INITIAL _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician/physical therapist will assist patients in obtaining insurance benefits when those benefits are assigned to my physician/physical therapist. It is my responsibility to make sure insurance payments are processed and paid promptly to my physician/physical therapist. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INITIAL _____

PATIENT'S SIGNATURE _____ **DATE** _____

Parent/Guardian _____ **DATE** _____

Mark S. Cantieri, D.O., F.A.A.O.
Edison Lakes Corporate Park
3555 Park Place West Suite 200
Mishawaka, IN 46545
(574) 271-8646 Office
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FINANCIAL POLICY

Welcome to Corrective Care! We are pleased you have selected our clinic to provide healthcare services. Please read this financial policy carefully so you understand - and agree to abide by - the payment terms outlined below.

Patients are responsible for contacting their own insurance company to verify coverage for medical treatment to be received at Corrective Care - *before* any actual treatment is rendered. You will find the procedure codes you will need for your insurance company's assessment and/or pre-certification approval on the teal-blue colored *Insurance Verification* form provided.

Payment is required for service rendered at the time of your appointment . For your convenience we accept: cash, checks, money orders, American Express, Discover, MasterCard and Visa credit cards. If monthly payment terms are desired, we offer several no interest/low interest CareCredit financing options.

We understand emergency situations sometimes occur and are happy to accommodate whatever schedule change you need. However, please keep in mind that we require at least a 24 hour notice of any appointment change desired. A $35.00 *non-cancellation notification* fee will be charged for no notice/no shows.

_____ *patient initials*

We are happy to file ***primary*** Insurance for our patients. Since all insurance companies do not pay the same benefits, nor have the same deductible, it is imperative that you provide correct - and current - coverage information. ***Please keep in mind that after the insurance company has reviewed your claim and paid what it will - any balance left becomes <u>your</u> responsibility to pay.*** This includes any provision for any out-of-network benefits, deductibles, co-pays or non-payment of non-covered services exclusions you may have on your own policy. It is the patient's responsibility to know, and understand, their own insurance benefits. If you have questions about *your* insurance plan benefits, coverage or claim processing/payment reimbursements, please speak with your employer who provides the health coverage to you. If your insurance policy has special requirements regarding office visits/procedures with a specialist, lab tests, rehabilitation, pre-certification, etc. please coordinate whatever is necessary *before* your appointment date.

Medical claims will be filed with your insurance company for you. If your claim is not paid within 45 days, a follow-up claim with a letter is sent to your insurance company requesting immediate payment or an explanation of any non-payment determination. After we re-submit the claim for you, the balance due will be moved to a "patient due" status and becomes *your* responsibility to pay.

Note: If your insurance company still does not respond after receiving our letter with the *second* claim, it becomes *your* responsibility to contact your insurance company to discover the reason for non-payment of the claim and help resolve any problems.

Note: If your insurance company makes payment of some services - yet denies payment on other services rendered on the same day (i.e. .. multiple injections or services), we will follow-up on the claim for you by sending a copy of our office notes; providing your insurance company with all the additional information necessary to successfully re-process your claim.

_____ *patient initials*

Charges for treatment given to **minor children** become the responsibility of the parent who authorizes the treatment. Corrective Care will not become involved in billing disputes or divorce decrees regarding payment responsibility.

_____ *patient initials*

Corrective Care physicians are participating **Medicare** service providers. Charges will be billed directly to Medicare for you. Please keep in mind that you are responsible for 20% co-payment, non covered services and any deductible amounts not paid by insurance. Statements will be sent to keep you informed of claim progress and **any amount not paid is *your* responsibility to pay**.

_____ *patient initials*

If you have a **motor vehicle accident** related problem - please contact our office and request a copy of our "Motor Vehicle Accident Policy". In addition to your *medical health insurance* information and copy of your membership card, we will also need your *auto insurance company* information: name, address, policy number, agent's name, contact phone number and date of the accident.

In most cases, we can bill your auto insurance company until your benefits are exhausted, then any remaining charges will be billed through your group health insurance plan. If there is an balance left after both insurance companies have paid what they will, the balance becomes *your* responsibility to pay.

In the event your claims are not paid by your insurance company after 45 days, it becomes *your* responsibility to pay the charges to Corrective Care and have your insurance company reimburse *you*.

If **litigation** is involved , your attorney can advise you about being reimbursed for medical expenses you've paid when your litigation is settled and a decision has been rendered in your favor.

Note: Corrective Care does not accept Letters of Protection nor will we become involved in any litigation or related proceedings.

_____ *patient initials*

Self-pay patients are required to pay for treatment rendered at time of service. For your convenience we accept cash, personal checks, money orders, American Express, Discover, MasterCard and Visa credit cards. We offer no interest/low interest CareCredit financing options if monthly payment terms are desired.

_____ *patient initials*

If you have a **workman's compensation** related problem, please bring the name, address and phone number of your employer, the insurance company covering your workman's comp claim, your claim number, your case manager's name and telephone number to your first appointment. We will be unable to process an insurance claim for you without this information and *you* will become responsible for payment of all medical care at that time.

_____ *patient initials*

Please Note: Corrective Care makes every attempt to be sure all required pre-certification of services you may receive here are done prior to your first visit. However, your insurance company has advised us that even though we obtain that pre-certification for services, it does not *guarantee* payment. In cases where a claim is denied for whatever reason (i.e. non-covered benefit under your plan, experimental, investigational , not medically necessary etc.) the charges become the responsibility of the patient or their guarantor.

I have read the above and understand that if my insurance company denies any charges for the medical care rendered to me by Corrective Care, I become responsible for payment of any amount dues.

I understand and agree to abide by the financial terms and conditions as outlined above.

_____ _____

Patient Signature *Date*

CORRECTIVE Care, PC
Edison Lakes Corporate Park
3555 Park Place West, Suite 200
Michawaka, IN 46545

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)* The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____ wish to be contacted in the following manner :

(Check all that apply)

☐ **Home Telephone** (____) _____

- ☐ O.K. to leave message with detailed information
  (re: ___ appointment ___ insurance ___ medical)
- ☐ O.K. to leave message with spouse/children
  (re: ___ appointment ___ insurance ___ medical)
- ☐ O.K. to leave message with others family member
  (re: ___ appointment ___ insurance ___ medical)
- ☐ Leave message with call-back number only

☐ **Work Telephone** (____) _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication**

- ☐ O.K. to mail to my home address
  (re: ___ appointment ___ insurance ___ medical)
- ☐ O.K. to mail to my work/office address
  (re: ___ appointment ___ insurance ___ medical)

_____

_____

- ☐ O.K. to fax to this number _____
  (re: ___ appointment ___ insurance ___ medical)

☐ **Other** _____

_____

_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided herein, if completed properly will constitute an adequate record.

NOTE: Uses and disclosures of PHI may be permitted without prior consent in an emergency.

Corrective Care is hereby authorized to discuss: *(Check all that apply)*

with my: ___ Spouse ___ Son/Daughter ___ Other family member ___ Employer ___ Other _____

- ☐ Appointment Information
- ☐ Account Information
- ☐ Insurance Information
- ☐ Medical Treatment Information
- ☐ Medication/Prescription Information
- ☐ Other _____

I, _____ hereby authorize any current employee of Corrective Care to use or disclose my personal health information as directed above. I have read this authorization and understand what information will be disclosed and that the disclosed information may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that this authorization remains in effect from the date of my signature below, unless I advise Corrective Care, in writing, of a change desired.

_____ Printed Name

_____ *Date*

_____ *Patient Signature*

_____ Date of Birth

March 21, 2003

Dear Patient:

I would like to take this opportunity to inform and educate you on a new policy that Corrective Care, P.C. will put in place to comply with the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations. The HIPAA privacy regulations are enforceable beginning April 14, 2003.

One option under the HIPAA privacy regulations is for Corrective Care, P.C. to define itself as an organized health care arrangement ("OCHA") and to issue a notice of privacy practices to every patient the first time they are seen at Corrective Care beginning April 14, 2003.

Corrective Care, P.C. believes that providing the attached notice of privacy practices will enable Corrective Care, P.C. and its medical staff to fulfill the HIPAA privacy obligations to each patient and reduce unnecessary paperwork under the regulations.

If you should have any questions regarding the HIPAA privacy regulations, any HIPAA policy adopted by Corrective Care, P.C. or the enclosed notice of privacy practices, please contact Corrective Care's Privacy Officer, Brenda Bellman at (574) 271-8646.

Sincerely,

Mark S. Cantieri, D.O., F.A.A.O.
C.E.O.

Mark S. Cantieri, D.O., F.A.A.O.
Edison Lakes Corporate Park
3555 Park Place West Suite 200
Mishawaka, IN 46545
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Notice of Privacy Practices

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
    - File a complaint with your provider or health insurer, or
    - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

Corrective Care. P.C.
3555 Park Place West, Suite 200
Mishawaka, IN 46545

Edison Lakes Corporate Park
3555 Park Place West, Suite 200
Mishawaka, IN 46545

Notice of Privacy Practices

Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Printed Name: _____

Signature: _____

Date: _____ _____

Received By